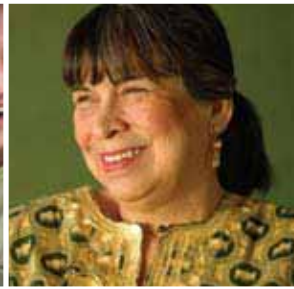
California Women's Health
2007





OWH OFFICE OF WOMEN'S HEALTH
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

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PREFACE

Improving the health of women and girls is one of the founding principles that guide the work of the California Department of Health Services (CDHS) Office of Women's Health (OWH). The OWH is charged with recommending and monitoring women's public health policies, promoting more comprehensive and effective approaches to improve women's health, enhancing the visibility and prominence of women's health needs, and advancing cost-effective and innovative solutions to address women's health problems. In addition, the OWH's mission includes guiding women's health policy in an effective and comprehensive fashion to promote health and reduce the burden of preventable disease and injury among the women and girls of California. The OWH fulfills these responsibilities through developing policy and resources, disseminating women's health resources to policy makers and the public, and developing a comprehensive framework for women's health policy and programs.

The OWH is pleased to present the first edition of California Women's Health. This report was inspired by Women's Health USA 2005, which is issued annually by the Health Resources and Services Administration's (HRSA) Office of Women's Health. To

reflect the ever changing, increasingly diverse population and its characteristics, California Women's Health 2007 includes emerging issues and trends in women's health. Information on household type, contraception, human trafficking, and border health are just a few of the California-related topics included in this edition. Where possible, we have attempted to highlight racial and ethnic disparities, as well as gender differences.

The OWH developed California's Women's Health 2007 to provide readers with an easy-to-use collection of current and historical data on some of the most pressing health challenges facing women, their families, and their communities. The report is intended to be a concise reference for policy makers and program managers at the federal, state, and local levels to help identify and clarify issues affecting the health of women and girls.

In these pages, readers will find a profile of women's health at the state level from a variety of data sources. This data book uses the latest available information from various departments within the California state government, including Health Services, and Finance.

Although we attempted to standardize terms and nomenclature, some variability was unavoidable due to the nature of the different sources. For example, the California Health Interview Survey (CHIS) has a large sample size that allows information access on a number of smaller race/ethnicity groups such as American Indian/Alaska Natives or Asians, whereas the California Women's Health Survey (CWHS) allows race/ethnicity breakdown to only four groups (White, Hispanic, Black/African American and Asian/Other). In other data sources, American Indian/Alaska Natives are sometimes referred to as Native Americans.

In this report, the term "women" refers to women aged 18 and older, and the term "females" designates the entire age spectrum (children and adults).

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INTRODUCTION

National statistics provide an overview of women's health across the nation. It is unclear, however, how accurately these statistics reflect the status of women's health in California because of its unique population. This report provides a snapshot of women's health in California so that state and county officials, policy makers, and health advocates can better understand the health status and needs of women in the state.

POPULATION CHARACTERISTICS

The demographics of California reflect its rich diversity. They tell the story of California women and provide some insight into the source of health disparities, which are linked to differences in education levels, socioeconomic status, and race.

California is home to 27.9 percent (9.5 million) of the nation's 34.2 million foreign-born population. These 9.5 million foreign-born people make up 27 percent of California's population. The number of foreign-born men and women is about equal. Nearly 80 percent of foreign-born women are between the ages of 18 and 64 years.

Females make up 51 percent of the state's population, with over 17 million women and girls. The majority of women are married, but a significant percentage (17 percent) live alone, and 15 percent are heads of households.

Poverty is a problem for nearly 3 million adults in California; almost 60 percent are women.

Although 56.9 percent of women are employed, women still are not paid the same as men in comparable positions. Economic, racial, and ethnic disparities continue to make women vulnerable. Racial and economic disparities also have implications for women's health.

HEALTH STATUS

Trends in health status help to identify new issues as they emerge. This report highlights various health behaviors, health indicators, reproductive and maternal health issues, and issues applicable to special populations that provide insight into the unique health care needs of California women.

Although Californians are reputed to be healthy and active, a growing trend towards obesity is affecting health and health care costs. Heart disease is the leading cause of death among women, and strokes are the third leading cause; together they

account for 40 percent of deaths among women in California. Breast cancer is the most common cancer among California women, followed by cancers of the digestive, reproductive and respiratory systems.

Arthritis is one of the most prevalent chronic health problems and is a leading cause of disability among Americans over age 15. In California, 23.0 percent of women report having been diagnosed with arthritis compared with 15.9 percent of men.

While men still account for the majority of **AIDS** cases in California, and women make up only 8 percent of AIDS cases, women's disease rates are increasing faster than men's in California.

The rate of **pregnancy-related mortality** in California has been increasing since the late 1990s. Black/African American women have higher pregnancy-related mortality than Hispanic and White women.

California's **teen birth rate** has dramatically declined since its peak in 1991. In 1999, it fell below the national average. This improved outcome is one of the bright spots in women's health in California.

The risk of **postpartum depression** is higher for women younger than 20 compared with older women of child-bearing age. Uninsured women are more at risk than insured women.

Mental health disorders disproportionately affect women. Native American women have the highest rates of emotional or mental health problems, and Asian women have the lowest.

Native American women have the highest rate of **mental health care use** compared with other racial/ethnic groups. Black/African American and Hispanic women are least likely to seek mental health services.

Women with **disabilities** are more likely to experience **intimate partner violence** than are other women. Seventy-one percent of women experiencing either intimate partner violence or frequent mental distress want mental health assistance, but less than half (46.5 percent) receive it. This level of unmet need has hidden consequences for women's health.

Homelessness and housing insecurity affect the health of both women and children in California. Nearly eight percent of women aged 18 years and older report experiencing housing insecurity. Sixty-four percent of those women have

children under age 18 in their household. Women under age 44, Black/ African Americans, and Hispanics are more likely than older women, Whites, and Asians to report housing insecurity.

Border populations and human trafficking are two special issues of concern for women's health in California. Human trafficking, a modern form of slavery, predominantly targets women. Years of abuse and trauma add stress to these women who suffer from a wide range of health problems.

HEALTH SERVICES UTILIZATION

The availability of and access to quality health services directly affect the health and well-being of women. This report presents data on women's health services utilization, including indicators of access to care, health insurance coverage, hospitalizations, mental health care utilization, and usual source of care by age, race/ ethnicity, and income.

Women make up 59 percent of patients discharged from hospitals. Pregnancy-related hospitalizations account for 30 percent of discharges. Black/African American women have the highest rates of conditions that can sometimes be prevented with proper primary care, such as asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and hypertension.

Teens between 12 and 17 years are the least likely among California females to have a usual source of care, while girls under age 11 and women 65 and older are the most likely. Hispanic and Native American women are less likely to have a usual source of care than White, Black/African American, and Asian women.

Women with low incomes are less likely than those with higher incomes to have a usual source of care. Women without insurance are less likely than those with insurance to seek preventive care services. Almost one third of Hispanic women and nearly one fifth of American Indian/Alaska Natives report being uninsured.

CONCLUSION

These trends in women's health have profound implications for future and ongoing health policy. It is important to understand the variations by race and ethnicity, age, and disease or condition among California women. Policies must address these variations; a one-size-fits-all approach will not work.

Despite the wide variety of health programs in California, many women are still falling through the cracks. There is a great need for expanding access to preventive care that in the long run will improve the health of women and provide savings to the state's health care system.



POPULATION CHARACTERISTICS

INTRODUCTION

Population characteristics describe the diverse social, demographic, and economic features of women and girls in California. Representing slightly more than half of the State's population, women and girls number over 17 million. Analysis and comparison of data across gender, age group, and race/ethnicity can be used to tailor the development and evaluation of programs and policies serving women's health. The following section presents data on population characteristics that affect women's health, including age, race/ethnicity, educational attainment, socio-economic status, household composition, marital status, and labor force participation.

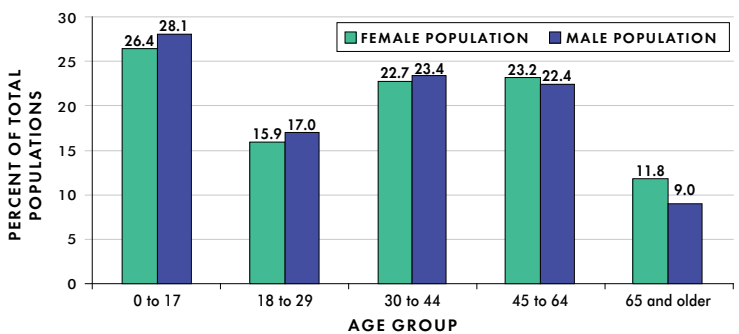
CALIFORNIA FEMALE POPULATION, BY AGE GROUP

In 2004, the California population reached over 35 million, with females composing 51 percent. Those aged 17 and under accounted for 26.4 percent of the female population, those aged 18 to 29 composed 15.9 percent, those aged 30 to 44 composed 22.7 percent, those aged 45 to 64 composed 23.2 percent, and females aged 65 and older accounted for 11.8 percent. Females between the ages of 30 and 64 were almost half of the total female population.

Higher proportions of males than females were present in every age group until age 45, reflecting men's shorter life expectancy: the median age for men was 33.2 years and was 35.2 years for women. Of people age 65 and older, more than 57 percent were women.

CALIFORNIA POPULATION, BY AGE GROUP AND GENDER, 2004

Source (I.1): U.S. Census Bureau, American Community Survey



NOTE: Each bar represents a percentage of the total population of that gender.

CALIFORNIA FEMALE POPULATION, BY AGE GROUP, 2004

Source (I.1): U.S. Census Bureau, American Community Survey

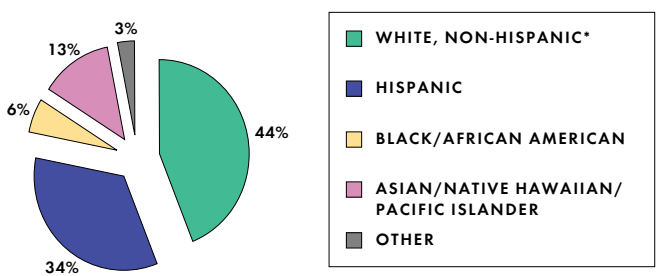
AGE GROUP	FEMALE POPULATION	PERCENT OF FEMALE POPULATION
0 to 17	4,667,934	26.4
18 to 29	2,818,263	15.9
30 to 44	4,008,094	22.7
45 to 64	4,103,329	23.2
65+	2,087,766	11.8
TOTAL	17,685,386	100

CALIFORNIA FEMALE POPULATION, BY RACE/ETHNICITY

California's diverse landscape is reflected in its female population. In 2004, the two largest female racial/ethnic groups were White-non-Hispanic (44 percent) and Hispanic (34 percent). Asian/Native Hawaiian/Pacific Islander composed 13 percent of the female population, and Black/African American females were 6 percent. American Indian/Alaskan Native females were less than 0.5 percent of the total female population.

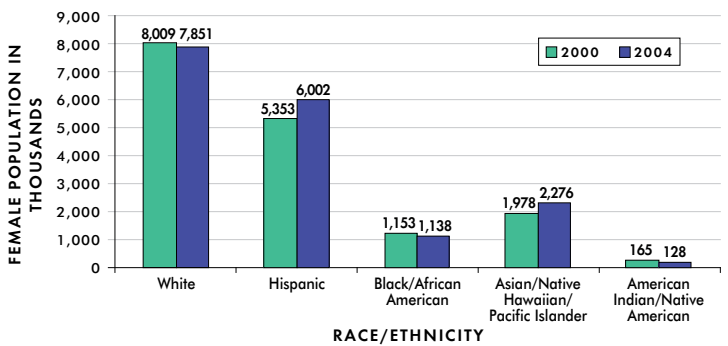
Significant population changes occurred within some races/ethnicities from 2000 to 2004: Hispanic (12 percent) and Asian/Native Hawaiian/Pacific Islander (15 percent) female populations increased. Decreases occurred in populations of White, Black/African American, and American Indian/Alaskan Native females.

CALIFORNIA FEMALE POPULATION, BY RACE/ETHNICITY, 2004
Source (I.1): U.S. Census Bureau, American Community Survey



* White, non-Hispanic will be titled White from now forward in the report.

CALIFORNIA FEMALE POPULATION, BY RACE/ETHNICITY, 2000 AND 2004 (IN THOUSANDS)
Source (I.3): U.S. Census Bureau, American Community Survey



ASIAN FEMALE POPULATION

Asian females in California are a diverse and growing group and include Chinese, Filipino, Japanese, Hmong, Pakistani, and Laotian women. In 2000, Chinese and Filipinos accounted for 52.3 percent of Asian females, and Vietnamese (11.7 percent) and Koreans (9.6 percent) composed the third and fourth largest groups of Asian females. Laotian, Thai, Pakistani, Indonesian, and Others[1] each accounted for one percent or less of the Asian female population.

1 *Other included groups whose population totaled less than 10,000.*

ASIAN FEMALE POPULATIONS, CALIFORNIA 2000
Source (I.2): U.S. Census Bureau

ASIAN POPULATION	FEMALE	PERCENT OF ASIAN FEMALE POPULATION
Chinese	510,209	26.6
Filipino	493,011	25.7
Vietnamese	223,555	11.7
Korean	183,732	9.6
Japanese	159,508	8.3
Asian Indian	143,407	7.5
Cambodian	37,069	1.9
Hmong	33,897	1.8
Laotian	28,137	1.5
Thai	20,533	1.1
Pakistani	9,210	<1
Indonesian	8,761	<1
Other[1]: Malaysian, Sri Lankan, Bangladeshi, Other	8,806	<1
Unspecified	57,227	3.0
TOTAL	1,917,062	100

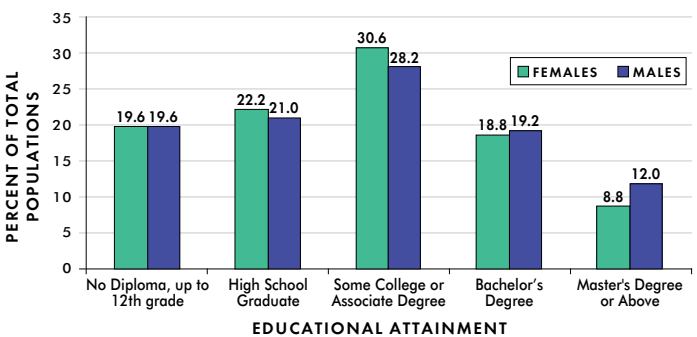
EDUCATIONAL ATTAINMENT

Women attain education at rates equal to or higher than men, except at the master's degree level and above. During 2004, women 25 years or older surpassed men in graduating from high school and attaining some college or an associate degree. The percentage of men (19.2 percent) and women (18.8 percent) attaining a bachelor's degree was similar. However, the percentage of men with a master's degree or above was higher than that of women (12.0 percent vs. 8.8 percent).

In 2004, a larger proportion of Asian women completed higher levels of education than women in other race/ethnicity groups. Nearly 45 percent of Hispanic women had a twelfth grade education or less and only 2.7 percent received a master's degree. Black/African American women had the highest levels (41.2 percent) of attaining some college or an associate degree, but were among the lowest levels receiving a master's degree (7.0 percent).

EDUCATIONAL ATTAINMENT FOR CALIFORNIA POPULATION 25 YEARS AND OLDER, BY GENDER, 2004

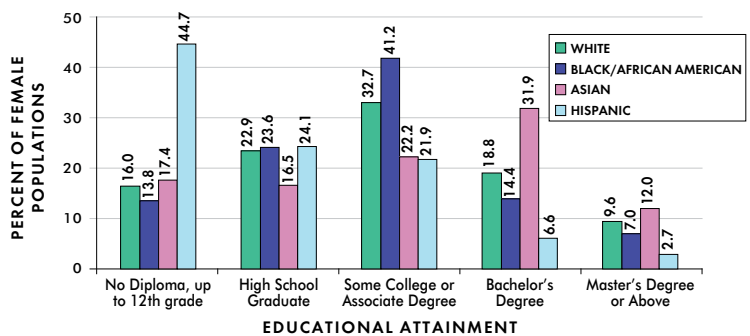
Source (I.1): U.S. Census Bureau, American Community Survey



NOTE: Each bar represents a percentage of the total population of that gender.

EDUCATIONAL ATTAINMENT FOR FEMALES 25 YEARS AND OLDER, BY RACE/ETHNICITY, CALIFORNIA 2004

Source (I.1): U.S. Census Bureau, American Community Survey



NOTE: Each bar represents a percentage of the female population of that race/ethnicity group.

FOREIGN-BORN FEMALES

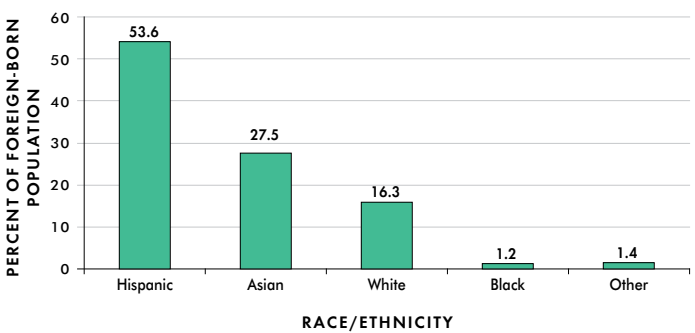
In 2004, California was home to 9.5 million foreign-born people, which was 27 percent of the state's population and 27.9 percent of the country's foreign-born population.[1] Hispanics were the majority of foreign-born residents (53.6 percent), followed by Asians (27.5 percent), Whites (16.3 percent), and Blacks (1.2 percent).[1] Mexico was the country of birth for 42.3 percent of the foreign-born population.[1]

In 2004, the distribution of foreign-born males and females was fairly balanced, but in the 65 and older age group there was a higher proportion of foreign-born females than males. Nearly 80 percent of the foreign-born female population was 18 to 64 years of age. School-aged girls were 7.1 percent of the total female foreign-born residents.

1 *California Department of Finance, Demographic Research Unit. Current Population Survey Report, March 2004.*

FOREIGN-BORN POPULATION, BY RACE/ETHNICITY, CALIFORNIA 2004

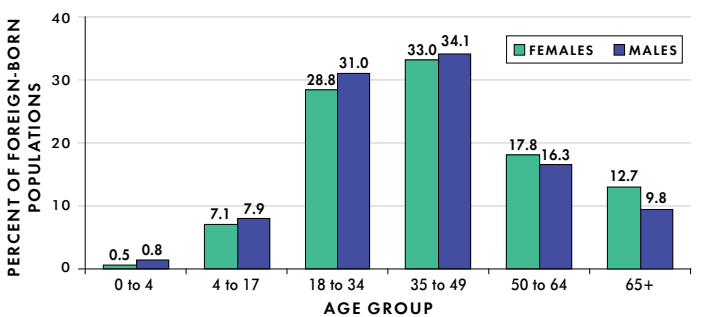
Source (III.1): California Department of Finance, Current Population Survey



NOTE: Each bar represents a percentage of the total foreign-born population.

FOREIGN-BORN POPULATION, BY AGE GROUP AND GENDER, CALIFORNIA 2004

Source (III.1): California Department of Finance, Current Population Survey



NOTE: Each bar represents a percentage of the foreign-born population of that gender.

POVERTY STATUS

In 2004, 1.7 million women and 1.2 million men aged 18 and older reported income in the past 12 months below the federal poverty level (FPL).[1] The FPL, set by the U.S. Census Bureau, varies depending on a person's family income, size, and composition.[1] For example, a single mother of two would meet federal poverty guidelines with an income of $15,670 or less a year.[2]

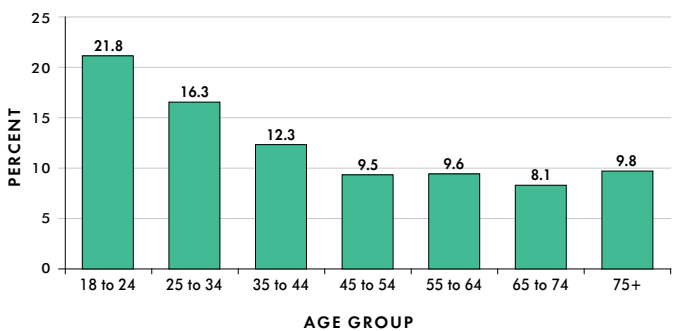
Women aged 18 to 24 years were more likely than women in other age groups to be poor; 21.8 percent of women in that age group lived below the FPL. The percentage of women living below the FPL continually decreased between the ages of 25 and 55, reaching a low of 9.5 percent for women aged 45 to 54. For women 75 and older, the percentage of women living below the FPL was higher than for women aged 65 to 74 (9.8 and 8.1 percent respectively).

About 21 percent of Black/African American women and 19 percent of Hispanic women reported living below the FPL. This was more than twice the rate reported by White women (8.1 percent). Nearly 12 percent of Asian women reported living below the FPL, which was comparable to the average for all races.

1 U.S. Census, Poverty Status. American Community Survey. 2004.
2 U.S. Department of Health and Human Services. Computations for the 2004 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia. Accessed May 2006 from http://aspe.hhs.gov/poverty/04computations.shtml

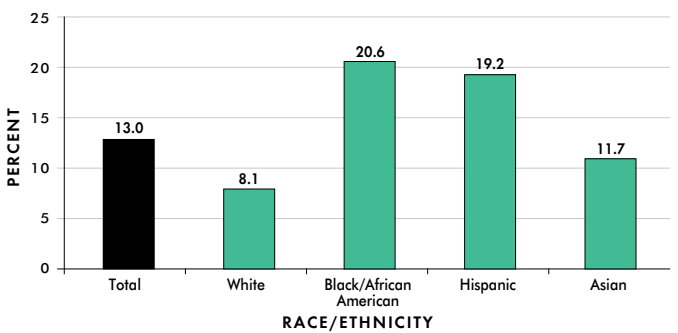
WOMEN LIVING BELOW FEDERAL POVERTY LEVEL (FPL), BY AGE GROUP, CALIFORNIA 2004

Source (I.1): U.S. Census Bureau, American Community Survey



WOMEN LIVING BELOW FEDERAL POVERTY LEVEL (FPL), BY RACE/ETHNICITY, CALIFORNIA 2004

Source (I.1): U.S. Census Bureau, American Community Survey

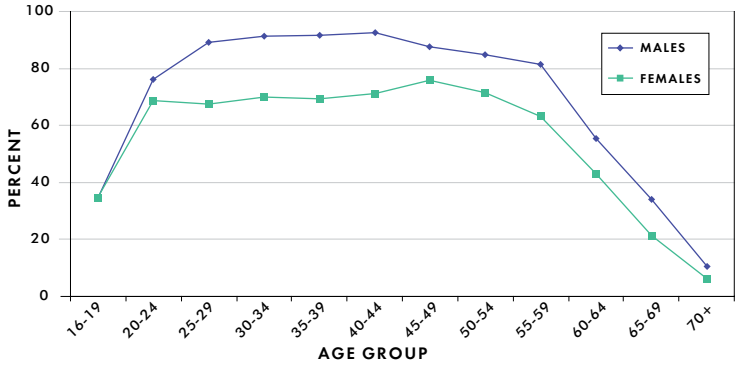


LABOR FORCE PARTICIPATION

During 2004, 17.3 million Californians were in the civilian labor force.[1] Participation rates in the civilian labor force were higher for males (72.6 percent) than females (56.9 percent).[1] Although females may be making strides in achieving equal employment with males, they were still not paid equally. In 2004, females aged 25 years and older earned 69.0

CIVILIAN LABOR FORCE PARTICIPATION IN CALIFORNIA, BY AGE GROUP AND GENDER, 2004

Source (III.1): California Department of Finance, Current Population Survey



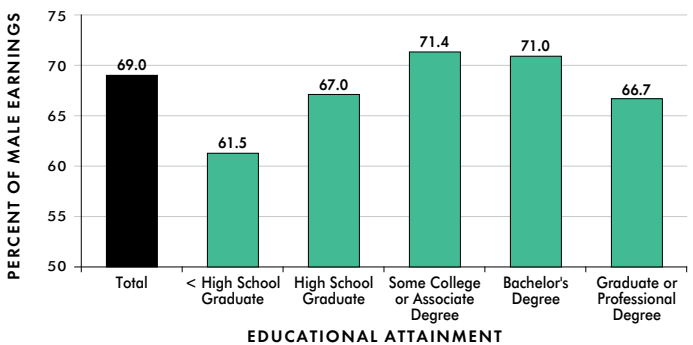
percent of males with the same educational level. The earning difference between genders varied with educational attainment. Females with less than a high school diploma earned 61.5 percent of their male counterparts. Females with some college, an associate degree, or a bachelor's degree earned the greatest proportion of male earnings (71.4 percent).

In 2004, the female unemployment rate was 6.9 percent.[1] Hispanic and Black/African American females had the highest unemployment rates (10.9 percent and 9.4 percent respectively). Unemployment among White females (4.4 percent) was more than 2 percent lower than the average unemployment rate for females (6.9 percent).

1 *California Department of Finance, Demographic Research Unit. Current Population Survey, March 2004.*

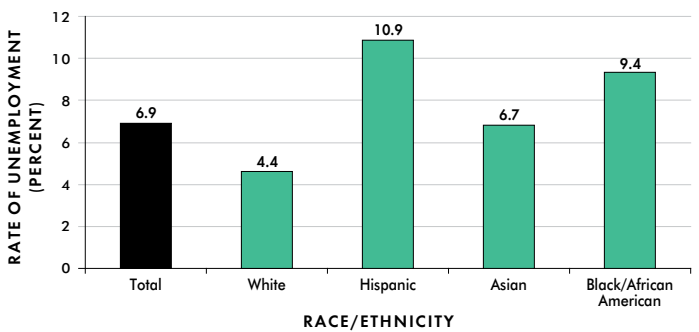
CALIFORNIA FEMALE EARNINGS AS A PERCENT OF MALE EARNINGS,BY EDUCATIONAL ATTAINMENT, CALIFORNIA 2004

Source (I.1): U.S. Census Bureau, American Community Survey



FEMALE UNEMPLOYMENT RATE, BY RACE/ETHNICITY, 2004

Source (III.1): California Department of Finance, Current Population Survey

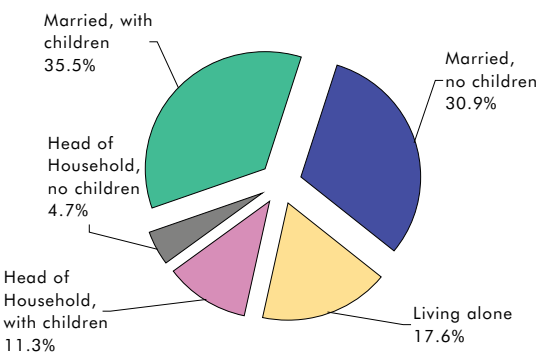


HOUSEHOLD COMPOSITION/MARITAL STATUS

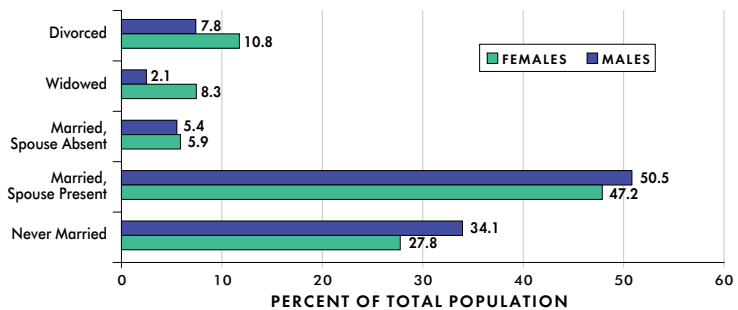
California residents vary significantly by household composition and marital status. In 2004, 16.0 percent of women were the head of a household, meaning that they had children or other relatives living with them, but had no spouse. Another 35.5 percent were married with children, while 30.9 percent were married with no children at home, and 17.6 percent of adult women lived alone.

A higher proportion of men than women either never married (34.1 percent men vs. 27.8 percent women) or were married with a spouse present (50.5 percent men vs. 47.2 percent women). A higher proportion of women were divorced than men (10.8 percent women vs. 7.8 percent men). Women were four times more likely to be widowed than were men (8.3 percent vs. 2.1 percent).

WOMEN, BY HOUSEHOLD COMPOSITION, CALIFORNIA 2004
Source (III.1): California Department of Finance, Current Population Survey



MARITAL STATUS*, BY GENDER, CALIFORNIA 2004
Source (I.1): U.S. Census Bureau, American Community Survey



* Marital status for the population 15 years and over.

NOTE: Each bar represents a percentage of the total population of that gender.




HEALTH STATUS

INTRODUCTION

The systematic assessment of women's health enables health professionals and policy makers to determine the impact of past and current health interventions and assess the need for new programs. Monitoring trends in health status helps to identify new issues as they emerge.

The following section presents health status indicators that relate to mortality, morbidity, health behaviors, and reproductive/maternal health. Issues pertinent to selected populations of women, including older women and victims of human trafficking, are also addressed. Where available, the data are displayed by gender, age group, and race/ethnicity.

HEALTH STATUS

HEALTH BEHAVIORS

- NUTRITION
- PHYSICAL ACTIVITY
- OBESITY

NUTRITION

Increasing fruit and vegetable consumption is an important healthy behavior that can help prevent heart disease, some cancers, high blood pressure, type 2 diabetes, and overweight and obesity.[1] In 2005, the U.S. Department of Agriculture's "Dietary Guidelines for Americans 2005" almost doubled the daily fruit and vegetable recommendation for women.[2]

The California Women's Health Survey (CWHS) in 2004 interviewed 4,434 participants to determine women's belief and practice of the prevailing fruit and vegetable dietary recommendations to eat five or more servings per day.[3] Sixty-one percent of California women reported that they should eat five or more servings of fruits and vegetables every day ("5 a Day"), while only 20.7 percent reported that they usually eat this amount.

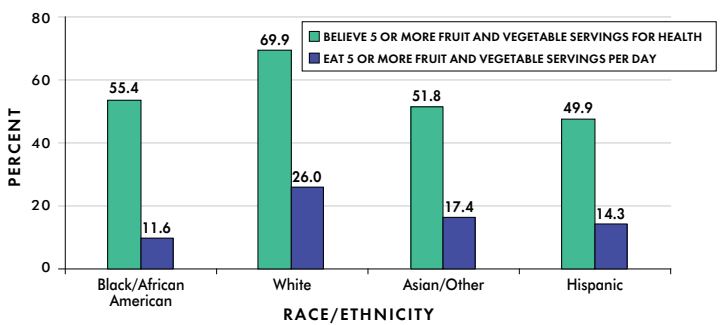
In California, women's five-a-day belief and practice varied by race/ethnicity and income level. White women were more likely to report that they should eat five or more servings of fruits and vegetables every day (69.9 percent), followed by Black/African American (55.4 percent), Asian/Other (51.8 percent), and Hispanic women (49.9 percent). Likewise, White women (26.0 percent) were more likely to report that they eat five or more servings of fruits and vegetables a day than Asian/Other (17.4 percent), Hispanic (14.3 percent) and Black/African American women (11.6 percent).

Women with incomes more than twice the federal poverty level (FPL) were more likely to report that they should eat five or more servings of fruits and vegetables a day than women with incomes below the FPL (69.4 percent versus 44.9 percent). Also, only 10.0 percent of respondents below the FPL reported eating five or more servings compared with 25.0 percent of the respondents whose income was more than twice the FPL.

In addition to the belief about eating fruits and vegetables for good health, it is important to consider whether those with incomes less than 200 percent of the FPL are able to afford enough food.[4] Only 59.8 percent of Hispanic women were food secure (able to afford enough food), leaving 40.2 percent of Hispanic women food insecure (not able to afford enough food). Fewer Asian women were food insecure (24.1 percent) compared with 29.0 percent of White women and 37.0 percent of Black/African American women.

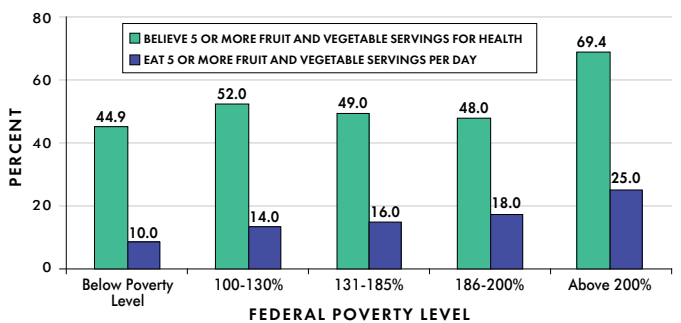
1 *U.S. Department of Health and Human Services, U.S. Department of Agriculture, "Dietary Guidelines for Americans 2005". www.healthierus.gov/dietaryguidelines.*
2 *Hyson, D. The health benefits of fruits and vegetables a scientific overview for health professionals. Produce for Better Health Foundation, 2002.*
3 *MkNelly B, Sugerman S, Mitchell P. 2006. Issue 4, Number 21: Eating Five or More Fruits and Vegetable Servings a Day: Belief versus Practice of California Women, 2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm*
4 *California Health Interview Survey (CHIS). Ask CHIS: http://www.chis.ucla.cdu/.*

CALIFORNIA WOMEN'S "5 A DAY" BELIEF AND PRACTICE, BY RACE/ETHNICITY, 2004
Source (II.1): California Women's Health Survey



Prepared by: California Department of Health Services, Cancer Prevention and Nutrition Section

CALIFORNIA WOMEN'S "5 A DAY" BELIEF AND PRACTICE, BY FEDERAL POVERTY LEVEL (FPL), 2004
Source (II.1): California Women's Health Survey



Prepared by: California Department of Health Services, Cancer Prevention and Nutrition Section

PHYSICAL ACTIVITY

Regular, moderate to intense physical activity promotes health, psychological well-being, and a healthy body weight. To reduce the risk of chronic disease, the current Dietary Guidelines for Americans recommend at least 30 minutes of moderate-intensity physical activity on most days of the week.[1] Physical inactivity is a significant problem among American adults, contributing to a host of health risk factors and conditions including obesity, hypertension, heart disease, diabetes, and cancer. Physical inactivity also contributes to increased health care costs. The cost of direct and indirect medical care, worker's compensation, and lost productivity attributable to physical inactivity, obesity, and overweight were estimated to be $21 billion in 2001.[2] Physical inactivity was estimated to cost Californians $13.3 billion in 2000. Costs have continued to rise: in 2005 it was estimated that physical inactivity, obesity, and overweight cost California $28 billion in direct and indirect medical care, workers' compensation, and lost productivity.[2]

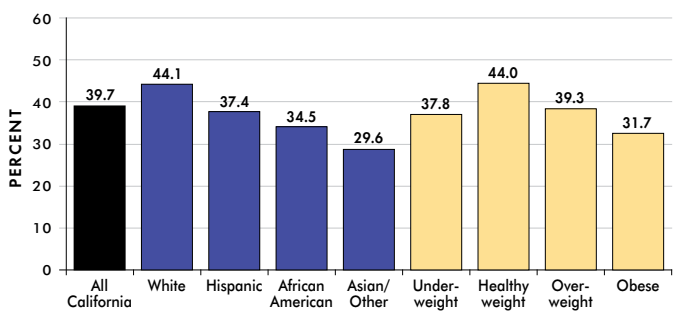
In 2004, California Women's Health Survey participants were asked how many days in a usual week and for how much time they do moderate or vigorous activity such as

brisk walking, bicycling, vacuuming, gardening, or anything else that causes some increase in breathing or heart rate.[3] Nearly 40 percent of all respondents reported meeting the physical activity guideline recommendations. White women met recommendations at 44.1 percent, followed by 37.4 percent of Hispanic women, 34.5 percent of Black/African American women, and 29.6 percent of Asian/Other women.

Over 51 percent of women reported not having enough time or being too busy or too tired as their main barriers to getting more physical activity. Medical issues were cited as reasons by 16.4 percent of women, laziness or "no reason" were cited by 12.4 percent, and 12.3 percent reported already getting enough exercise.

1 *U.S. Department of Health and Human Services and U.S. Department of Agriculture, Dietary Guidelines for Americans, 2005, 6th Edition, Washington D.C.: U.S. Government Printing Office, January 2005.*
2 *Chenoweth D. 2005. The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults during the Year 2000: A Technical Analysis. California Department of Health Services, Cancer Prevention and Nutrition Section and Epidemiology and Health Promotion Section.*
3 *MkNelly B, Sugerman S, Mitchell P. 2006. Issue 4, Number 23: Achievement of Recommended Levels of Physical Activity Among California Women. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

WOMEN WHO REPORTED 30 MINUTES/DAY OF PHYSICAL ACTIVITY AT LEAST FIVE DAYS/WEEK, CALFORNIA 2004
Source (II.1): California Women's Health Survey



Prepared by: California Department of Health Services, Cancer Prevention and Nutrition Section

OBESITY

Obesity increases the risk of numerous ailments, including hypertension, diabetes, heart disease, stroke, arthritis, cancer, and poor reproductive health.[1,2] Obesity also contributes to increased health care costs. Obesity was estimated to cost Californians $6.4 billion in 2000 for direct and indirect medical care, workers' compensation, and lost productivty.[1] When combined with lack of physical activity and overweight, total health care and lost productivity were estimated to cost $21 billion.[2] Costs have continued to rise: in 2005, physical inactivity, obesity, and overweight cost California an estimated $28 billion.[3]

In 2004, participants in the California Women's Health Survey (who were either not pregnant or within one year post-pregnancy) were asked to report height and weight, which were used to calculate their body mass index (BMI).[4] Obesity is defined as a BMI of 30 or more. The U.S. Department of Health and Human Services Healthy People 2010 goal is to reduce obesity to 15 percent of the population.[5] In 2004, 23.2 percent of California women were obese. Obesity prevalence varied significantly by respondents' demographic characteristics and poverty-related variables.

Educational attainment was inversely associated with obesity. Women with less than a high school education were more likely to be obese (36.0 percent). Women with a high school diploma (26.3 percent), some college (25.3 percent), and who had graduated from college (14.2 percent) were less likely to be obese.

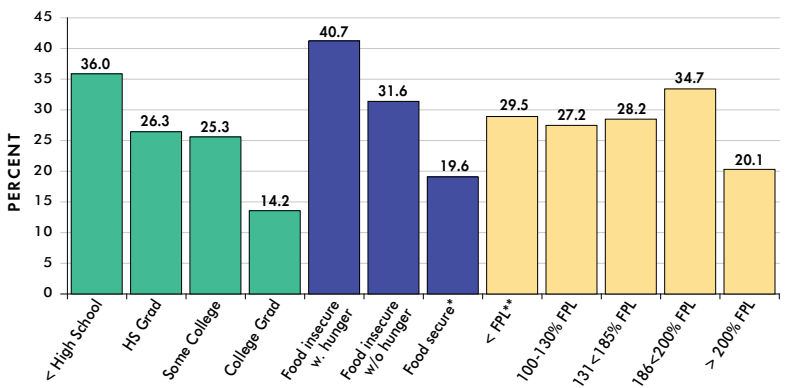
Poverty-related factors were highly associated with obesity. Obesity increased with the degree of food insecurity. Food-insecure women (those not able to afford enough food) with hunger had the highest levels of obesity (40.7 percent), while food-insecure women without hunger had significantly lower levels of obesity (31.6 percent). Food-secure women (those able to afford enough food) had the lowest levels of obesity (19.6 percent). Women with household incomes over 200 percent of the federal poverty level had a significantly lower rate of obesity (20.1 percent) than women with lower household incomes, whose obesity rates did not differ significantly from one another.

Racial/ethnic groups differed in their obesity rates. Asian/Other women had the lowest obesity rate at 12.0

percent, followed by White women at 21.1 percent. Obesity rates were highest among Hispanic (32.2 percent) and Black/African American (33.1 percent) women.

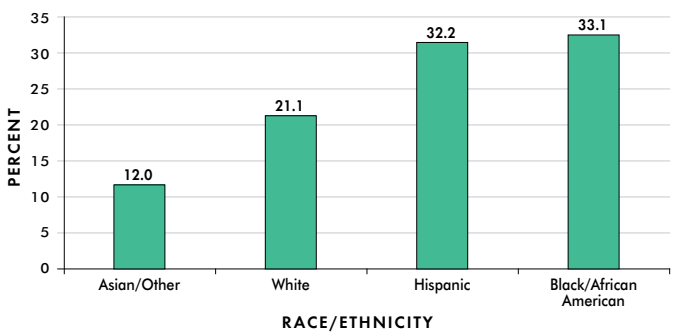
1 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Overweight and obesity: Health consequences. April 2006, http://www.cdc.gov/nccdphp/dnpa/obesity/consequences.htm.
2 Linne Y. Effects of obesity on women's reproduction and complications during pregnancy. Obes Rev. 2004 Aug; S(3): 137-43.
3 Chenoweth D. 2005. The Economic Costs of Physical Inactivity, Obesity, and Overweight in California Adults during the Year 2000: A Technical Analysis. California Department of Health Services, Cancer Prevention and Nutrition Section and Epidemiology and Health Promotion Section.
4 Sugerman S, MkNelly B, Mitchell P. 2006. Issue 4, Number 25: Prevalence of Obesity and Disparities in Obesity-Related Factors Among California Women, 2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm
5 U.S. Department of Health and Human Services. 2000. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: http://www.healthypeople.gov/document/html/volume2/19nutrition.htm.

PREVALENCE OF OBESITY BY EDUCATION AND POVERTY RELATED FACTORS, CALIFORNIA 2004
Source (II.1): California Women's Health Survey



* Food secure = having access, at all times, to enough food for an active healthy life.
** FPL = Federal Poverty Level

OBESITY RATE OF WOMEN, BY RACE/ETHNICITY, CALIFORNIA 2004
Source (II.1): California Women's Health Survey



Prepared by: California Department of Health Services, Cancer Prevention and Nutrition Section.




HEALTH STATUS

HEALTH INDICATORS

- AIDS
- HIV
- HEALTH CARE PROVIDER DISCUSSION ABOUT HIV RISK
- ARTHRITIS
- ASTHMA
- DIABETES
- CANCER
- OSTEOPOROSIS
- HYPERTENSION
- HEART DISEASE AND STROKE
- ORAL HEALTH AND DENTAL CARE
- SEXUALLY TRANSMITTED DISEASE - CHLAMYDIA
- SELF-REPORTED HEALTH STATUS
- INJURY
- INTIMATE PARTNER VIOLENCE AND DISABILITIES
- INTIMATE PARTNER VIOLENCE AND MENTAL HEALTH
- LEADING CAUSES OF DEATH
- MENTAL HEALTH
- SUICIDE

AIDS

While men still account for the majority of AIDS cases in California, the problem has increased among females. By 2002, females made up 8 percent of AIDS cases in California, and the incidence was growing at a faster rate than in males.[1]

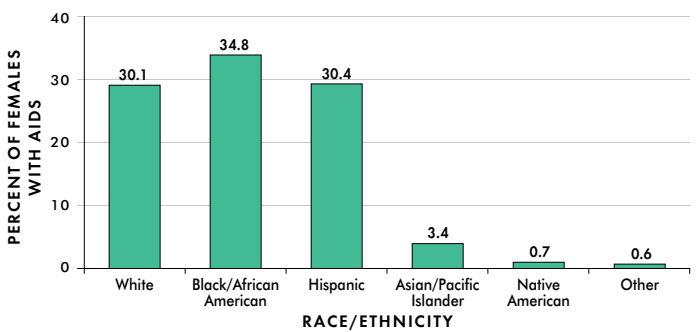
In California, significant racial/ethnic disparities exist among female AIDS cases. Black/African Americans account for 34.8 percent of females with AIDS, while accounting for only 6 percent of the total female population. Whites account for 30.1 percent of females with AIDS, Hispanics for 30.4 percent, Asian/Pacific Islanders 3.4 percent, and Native Americans 0.7 percent.

The five leading modes of exposure in females living with AIDS were: 1) heterosexual contact with a partner with a known risk factor for HIV (50.1 percent), 2) injection drug use (30.7 percent), 3) no identified risk (this includes heterosexual contact with partners with no known risk factors for HIV) (13.9 percent), 4) transfusion/transplant/hemophiliac (3.6 percent), and 5) pediatric exposure from an at-risk mother (1.8 percent).

1 California Department of Health Services. Office of AIDS. Women and HIV/AIDS in California: Fact Sheet, 2002.

RACE/ETHNICITY OF CALIFORNIA FEMALES LIVING WITH AIDS, CUMULATIVE AS OF JANUARY 31, 2006

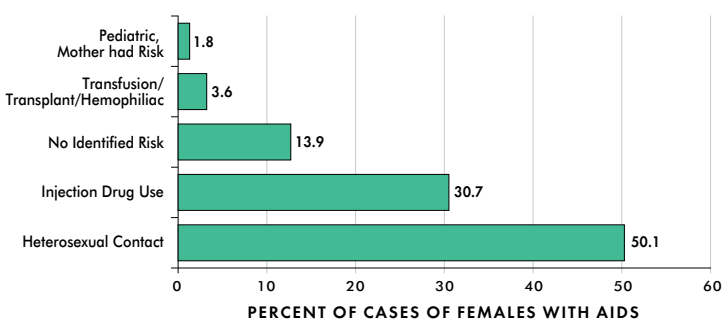
Source (II.2): California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry Section



NOTE: Each bar represents a percentage of the population of females with AIDS.

LEADING MODES OF EXPOSURE AMONG CALIFORNIA FEMALES WITH AIDS, CUMULATIVE AS OF JANUARY 31, 2006

Source (II.2): California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry Section



NOTE: Each bar represents a percentage of the population of females with AIDS.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

HIV is the virus that causes AIDS.[1] Females make up about 14 percent of HIV cases.[2] In California, reporting of HIV case data started on July 1, 2002.

In California, dramatic racial/ethnic disparities exist among females with HIV. Black/African Americans account for 35.6 percent of females infected with HIV while accounting for only 6 percent of the female population. Whites (27.2 percent) and Hispanics (30.2 percent) account for most of the remaining female HIV cases, while Asian/Pacific Islander (3.2 percent) and Native American (0.8 percent) females account for the lowest proportions.

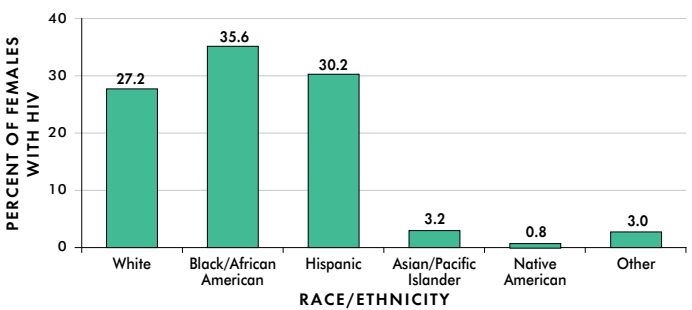
The five leading ways that females reported that they were exposed to HIV were: 1) heterosexual contact with a partner with a known risk factor for HIV (42.8 percent), 2) injection drug use (21.2 percent), 3) no identified risk (this includes heterosexual contact with partners with no known risk factors for HIV) (30.9 percent), 4) transfusion/transplant/hemophiliac (1.5 percent), and 5) pediatric exposure from an at-risk mother (3.5 percent).

1 *California Department of Health Services. 2002. Office of AIDS. Women and HIV/AIDS in California: Fact Sheet.*

2 *California Department of Health Services. Office of AIDS, HIV/AIDS Case Registry Section. January 31, 2006.*

RACE/ETHNICITY OF CALIFORNIA FEMALES WITH HIV, CUMULATIVE AS OF JANUARY 31, 2006*

Source (II.5): California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry Section

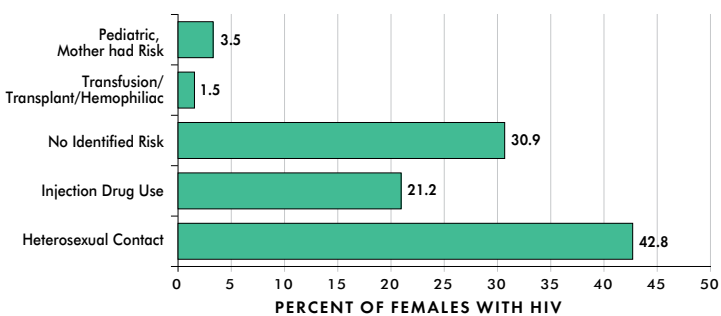


* HIV case data collection started on July 1, 2002.

NOTE: Each bar represents a percentage of the population of females with HIV.

LEADING MODES OF EXPOSURE AMONG CALIFORNIA FEMALES WITH HIV, CUMULATIVE AS OF JANUARY 31, 2006*

Source (II.5): California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry Section



* HIV case data collection started on July 1, 2002.

NOTE: Each bar represents a percentage of the population of females with HIV.

HEALTH CARE PROVIDER DISCUSSION ABOUT HIV RISK

Today most people aware of their HIV status know that effective treatments are now available. Knowledge of HIV serostatus is also important so that antiretroviral therapy and counseling can be started to prevent further sexual and perinatal transmission.[1]

In 2003, the OWH sponsored questions in the annual California Women's Health Survey asking respondents whether they had been asked by their health care provider in the previous 12 months about their risk for HIV.[2]

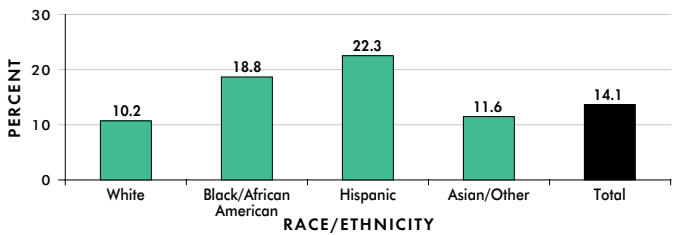
About 14 percent of the respondents reported that a health care provider had talked with them about their personal risk for HIV during the previous 12 months. Respondents reporting HIV discussions varied significantly by race/ethnicity and age: respondents who were younger, Hispanic (22.3 percent), or Black/African American (18.8 percent) reported higher rates.

1 *Centers for Disease Control and Prevention. http://www.cdc.gov/hiv/topics/prev_prog/AHP/resources/qa/AHP_Science.htm.*

2 *Weinbaum Z, Thorfinnson T. 2006. Issue 4, Number 14: Health care Provider Discussion About HIV Risk, California, 2003. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

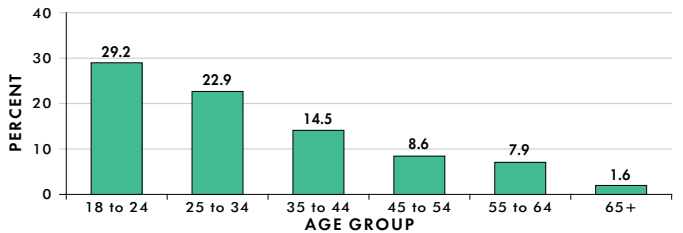
WOMEN REPORTING THAT A HEALTH CARE PROVIDER DISCUSSED HIV RISKS WITH THEM DURING THE PAST 12 MONTHS, BY RACE/ETHNICITY, CALIFORNIA 2003

Source (II.1): California Women's Health Survey



WOMEN REPORTING THAT A HEALTH CARE PROVIDER DISCUSSED HIV RISKS WITH THEM DURING THE PAST 12 MONTHS, BY AGE GROUP, CALIFORNIA 2003

Source (II.1): California Women's Health Survey



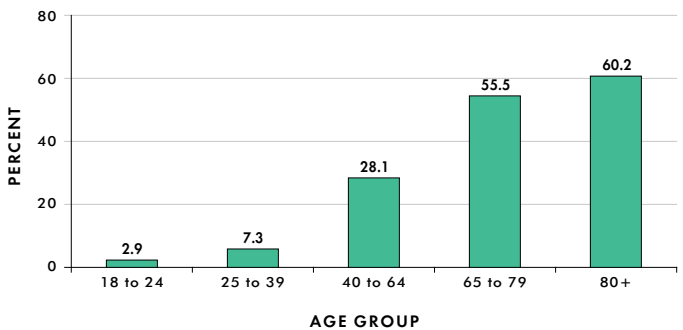
ARTHRITIS

Arthritis is one of the most common chronic health problems and is a leading cause of disability. Arthritis refers to more than 100 diseases that affect areas in or around joints.[1] Some types of arthritis are osteoarthritis, rheumatoid arthritis, gout, ankylosing spondylitis, systemic lupus erythematosus (lupus), scleroderma, and fibromyalgia.[1]

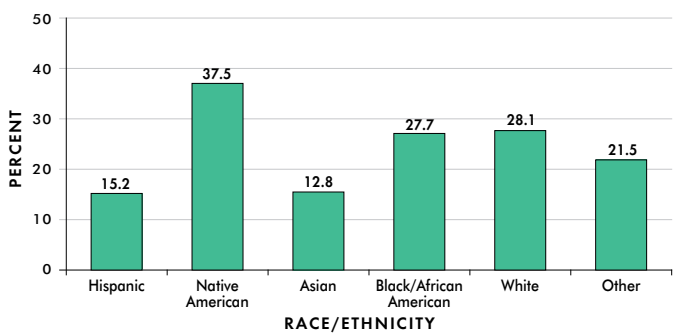
In 2003, a higher proportion of women than men in California reported that they were diagnosed with arthritis (15.9 percent for men and 23.0 percent for women).[2] The prevalence of arthritis was higher as women aged, with more than half of women older than 65 reporting having been diagnosed with the condition. The prevalence of arthritis varied by race/ethnicity, with Native American women reporting the highest prevalence (37.5 percent), followed by Whites (28.1 percent). Asians reported the lowest prevalence (12.8 percent).

1 Arthritis Foundation. http://www.arthritis.org/resources/gettingstarted/default.asp.
2 California Health Interview Survey (CHIS). AskCHIS: http://www.chis.ucla.edu/.

CALIFORNIA WOMEN REPORTING EVER BEING DIAGNOSED WITH ARTHRITIS, BY AGE GROUP, CALIFORNIA 2003
Source (II.3): California Health Interview Survey



CALIFORNIA WOMEN REPORTING EVER BEING DIAGNOSED WITH ARTHRITIS, BY RACE/ETHNICITY, CALIFORNIA 2003
Source (II.3): California Health Interview Survey



ASTHMA

Asthma is a chronic respiratory disease that can cause wheezing, shortness of breath, coughing, and chest tightness.[1] In 2004, the OWH sponsored questions in the annual California Women's Health Survey asking respondents whether they had ever been told by a health care professional that they had asthma, and whether they still had the disease.[2]

The survey found that 15.5 percent of California women had been diagnosed with asthma at some point in their life. Of those, 64.2 percent said that they still had asthma (9.9 percent of all the respondents). Asthma rates varied significantly by race/ethnicity.

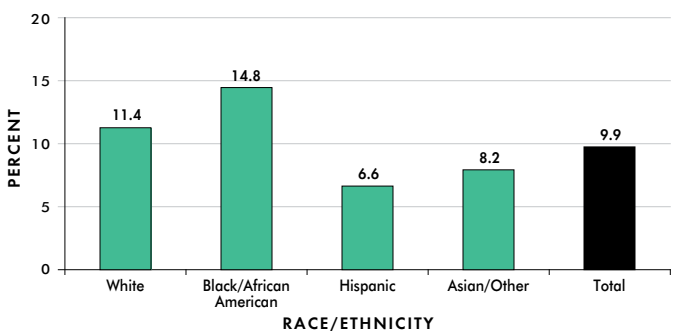
The highest asthma prevalence was among Black/African American women (14.8 percent), followed by Whites (11.4 percent), Asian/Others (8.2 percent), and Hispanics (6.6 percent). Asthma rates varied significantly by age group.

1 *Centers for Disease Control and Prevention. http://www.cdc.gov/asthma/faqs.htm.*

2 *Weinbaum Z, Thorfinnson T. 2006. Issue 4, Number 10: Asthma Among Adult California Women, 2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.Points.*

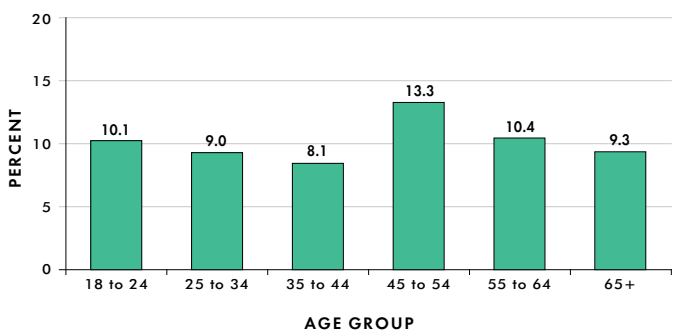
CALIFORNIA WOMEN REPORTING THAT THEY HAVE ASTHMA, BY RACE/ETHNICITY, CALIFORNIA 2004

Source (II.1): California Women's Health Survey



CALIFORNIA WOMEN REPORTING THAT THEY HAVE ASTHMA, BY AGE GROUP, CALIFORNIA 2004

Source (II.1): California Women's Health Survey



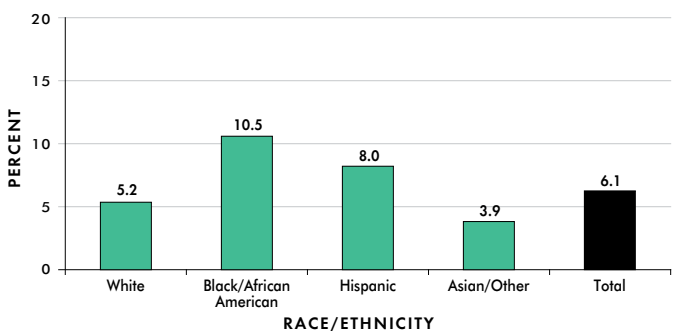
DIABETES

Diabetes is a chronic disease that can lead to death and disability.[1] It is indicated by high levels of blood glucose resulting from defects in insulin production, insulin action, or both.[2] In 2004, the OWH sponsored questions in the annual California Women's Health Survey asking respondents aged 18 and above if they had ever been told by a health care professional that they had diabetes.[2]

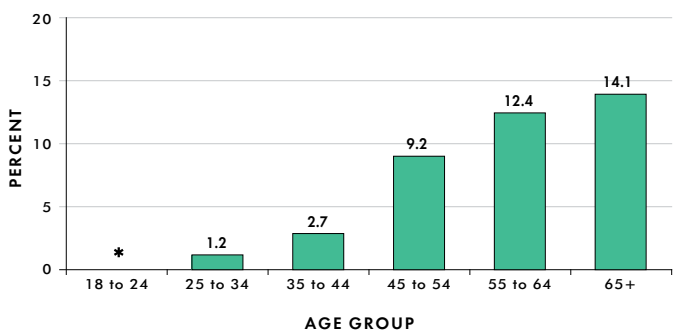
About 6.1 percent of respondents reported having been told that they had diabetes (excluding pregnancy-related diabetes). Diabetes rates varied significantly by race/ethnicity and age group. Black/African American women reported the highest diabetes rates at 10.5 percent, followed by Hispanics (8.0 percent), Whites (5.2 percent), and Asians/Others (3.9 percent). The likelihood of having been diagnosed with diabetes increased with age.

1 *Centers for Disease Control and Prevention (CDC). http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2005.pdf.*
2 *Weinbaum Z, Thorfinnson T. 2006. Issue 4, Number 8: Diabetes Among California Women, 2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.Points.*

CALIFORNIA WOMEN REPORTING EVER BEING TOLD THAT THEY HAVE DIABETES, BY RACE/ETHNICITY, 2004
Source (II.1): California Women's Health Survey



CALIFORNIA WOMEN REPORTING EVER BEING TOLD THAT THEY HAVE DIABETES, BY AGE GROUP, CALIFORNIA, 2004
Source (II.1): California Women's Health Survey



* Sample size too small for the 18-24 age group – findings are unreliable

CANCER

An estimated 66,150 California women were diagnosed with cancer and 25,725 women died of the disease in 2005.[1] In 2000, breast cancer was the most common cancer diagnosed in California women (132.5 per 100,000), followed by cancers of the digestive system (70.5 per 100,000), reproductive system (51.3 per 100,000), and lung and bronchus (47.7 per 100,000).[2] Among the race/ethnicity groups, Whites and Black/African Americans had the highest rates of breast cancer (154.2 and 123.6 per 100,000 respectively).

Mortality among women from lung and bronchus cancer was the highest compared with other cancers (36.9 per 100,000), followed by cancer of the digestive system (35.9 per 100,000), breast cancer (25.0 per 100,000), and reproductive system cancers (16.4 per 100,000). But this pattern was not evident in all the race/ethnicity groups: mortality among White women was highest from lung cancer (43.8 per 100,000), while mortality among the remaining race/ethnicity groups was highest from cancer of the digestive system. Black/African American women had the highest overall cancer mortality rates.

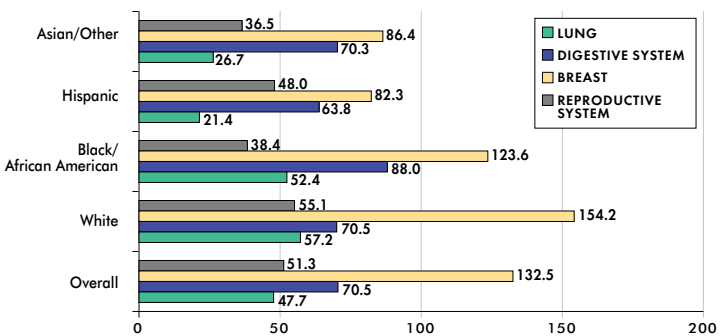
Early detection of cancer can save lives and substantially reduce the cost of cancer treatment. The Centers for Disease

Control and Prevention and the U.S. Preventive Services Task Force recommend screening for some cancers.[3,4] Screening recommendations include mammography with or without clinical breast examination every one to two years for women aged 40 and older for breast cancer, and pap smear screening (in women who have been sexually active and have a cervix) for cervical cancer. They also recommend colorectal cancer screening for women 50 years or older and that clinicians ask about tobacco use.

1 *California Department of Health Services. California Cancer Registry. http://www.ccrcal.org/PDF/ACS2005.pdf.*
2 *California Department of Health Services. California Cancer Registry. http://www.ccrcal.org/PDF/Min2003.pdf.*
3 *Centers for Disease Control and Prevention (CDC). http://www.cdc.gov/nccdphp/publications/factsheets/Prevention/cancer.htm.*
4 *U.S Department of Health and Human Services. Agency for Health care Research and Quality. http://www.ahrq.gov/clinic/cps3dix.htm#cancer.*

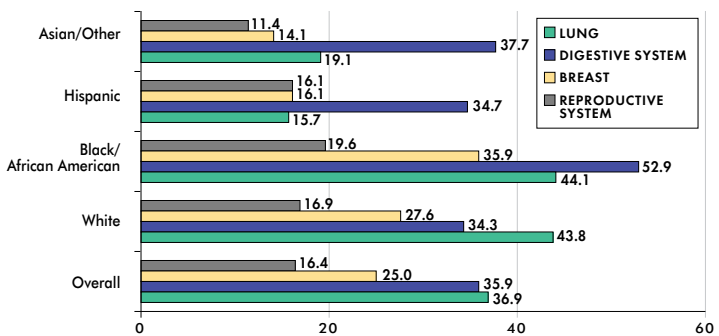
INCIDENCE OF CANCER, PRIMARY SITE, AGE-ADJUSTED RATES PER 100,000, CALIFORNIA WOMEN 2000

Source (II.4): California Department of Health Services, California Cancer Registry



MORTALITY FROM CANCER, PRIMARY SITE, AGE-ADJUSTED RATES PER 100,000, CALIFORNIA WOMEN 2000

Source (II.4): California Department of Health Services, California Cancer Registry



OSTEOPOROSIS

Approximately five million Californians, 80 percent of whom are women, are estimated to have osteoporosis.[1] Osteoporosis is the most common underlying cause of bone fracture in the elderly, but it is not frequently diagnosed or treated, even in individuals who have already suffered a fracture. Osteoporosis is characterized by progressive loss of bone density and thinning of bone tissue, leading to vulnerability to bone fractures causing chronic pain, permanent disability, loss of independence, and death. Risk factors for osteoporosis include female gender, older age, small or thin body size, White or Asian ethnicity, and family history of fractures. Modifiable risk factors include a diet low in calcium and vitamin D, use of certain medications, an inactive lifestyle or extended bed rest, cigarette smoking, and excessive alcohol consumption.[2]

In 2001, the California Department of Health Services Center for Health Statistics reported that only 35.2 percent of women aged 50 and older have ever had a bone density test, resulting in nearly 65 percent of women aged 50 and older (more than 3 million women) who were unaware if they were suffering from bone loss, osteopenia, or osteoporosis. [3]

The proportion of women diagnosed with bone loss, osteopenia, or osteoporosis varies among race/ethnicity groups. Higher proportions of Asian women, aged 50 and older (43.5 percent) have been diagnosed with bone loss, osteopenia, or osteoporosis than Whites (42.4 percent), American Indians/ Alaska Natives (41.0 percent), Hispanics (38.2 percent), and Black/African Americans (29.0 percent) of the same age.

1 *Women's Health: Findings from the California Women's Health Survey, 1997-2003, Chapter 11: Awareness and Prevalence of Osteoporosis Among California Women. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm*

2 *Osteoporosis and Related Bone Diseases National Resource Center. Osteoporosis Overview. National Institutes of Health, October 2002.*

3 *California Department of Health Services, Center for Health Statistics. Osteoporosis Risk in California Counties, 2001.*

CALIFORNIA WOMEN 50 YEARS AND OLDER DIAGNOSED WITH BONE LOSS, OSTEOPENIA, OR OSTEOPOROSIS, BY RACE/ETHNICITY, 2001

Source (II.9): California Health Interview Survey

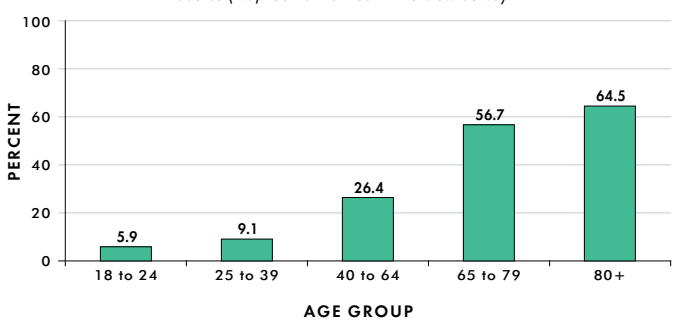
HYPERTENSION

Hypertension, also known as high blood pressure, is a risk factor for heart disease and stroke. Blood pressure is defined by two numbers: the top (systolic) number representing the pressure while the heart is beating, and the bottom (diastolic) number representing the pressure when the heart is resting between beats. High blood pressure for adults is defined as having a systolic pressure of 140 mmHg or higher, or a diastolic pressure of 90 mmHg or higher.[1]

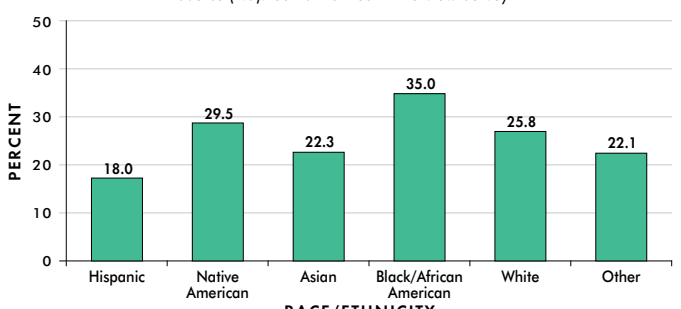
In 2003, the proportion of California women reporting that they were diagnosed with high blood pressure was slightly higher than of men (24.0 percent for women and 23.0 percent for men).[2] High blood pressure was diagnosed more in older women, with more than half of those in the 65+ age groups having been diagnosed. Rates of high blood pressure varied by race/ethnicity, with Black/African American women reporting the highest rate (35.0 percent) and Hispanics reporting the lowest (18.0 percent).

1 *Centers for Disease Control and Prevention. http://www.cdc.gov/cvh/library/fs_bloodpressure.htm.*
2 *California Health Interview Survey (CHIS). AskCHIS. http://www.chis.ucla.edu/.*

CALIFORNIA WOMEN REPORTING BEING DIAGNOSED WITH HIGH BLOOD PRESSURE, BY AGE GROUP, CALIFORNIA 2003
Source (II.3): California Health Interview Survey



CALIFORNIA WOMEN REPORTING BEING DIAGNOSED WITH HIGH BLOOD PRESSURE, BY RACE/ETHNICITY, CALIFORNIA 2003
Source (II.3): California Health Interview Survey



HEART DISEASE AND STROKE

Heart disease and stroke are among the leading causes of death for women in California and are responsible for about 40 percent of deaths of California women. The age-adjusted rate of heart disease, the leading cause of death in 2002, was 180.5 per 100,000; stroke deaths, the third leading cause of death in women, occurred at a rate of 55.3 per 100,000.[1]

Of adult women in California surveyed in 2004, 5.9 percent (estimated to represent 690,000 women) reported that a health care professional had told them that they had heart disease or a stroke.[2]

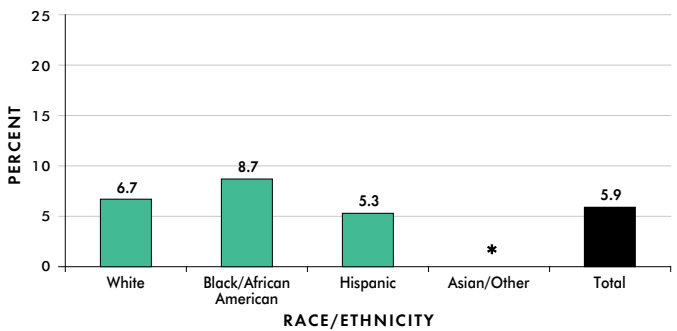
Among the race/ethnicity groups, 8.7 percent of Black/African American, 6.7 percent of White, and 5.3 percent of Hispanic women reported that a health care professional had told them that they had heart disease/stroke. Having heart disease or a stroke was highly related to the age of the respondent, with older women reporting higher rates of heart disease/stroke.

1 *California Department of Health Services. Vital Statistics of California, 2002. http://www.dhs.ca.gov/hisp/chs/OHIR/Publication/Highlights/VSC2002/VSC2002.pdf.*

2 *Weinbaum Z, Thorfinnson T. 2006. Issue 4, Number 7: Heart Disease or Stroke Status Among California Women, 2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

CALIFORNIA WOMEN REPORTING EVER BEING TOLD THAT THEY HAVE HEART DISEASE/STROKE, BY RACE/ETHNICITY, CALIFORNIA 2004

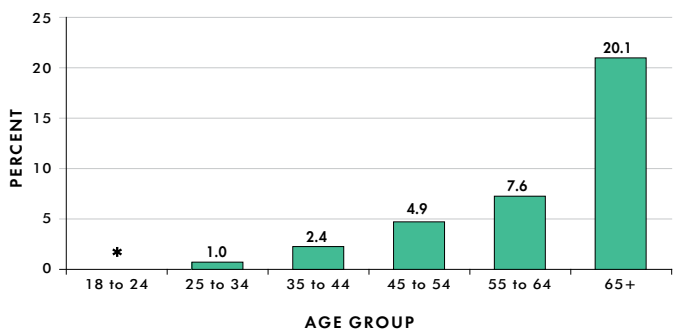
Source (II.1): California Women's Health Survey



* Sample size too small for Asian/Other race/ethnicity – findings are unreliable

CALIFORNIA WOMEN REPORTING EVER BEING TOLD THAT THEY HAVE HEART DISEASE/STROKE, BY AGE GROUP, CALIFORNIA 2004

Source (II.1): California Women's Health Survey



* Sample size too small for the 18-24 age group – findings are unreliable

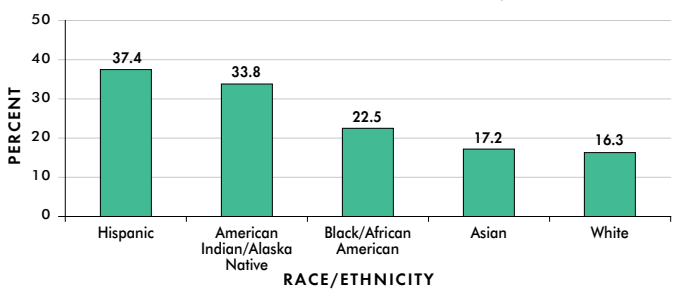
ORAL HEALTH AND DENTAL CARE

Proper dental care is important for preventing cavities and maintaining overall oral health. Oral health can have broad health implications: oral disease can cause chronic pain of the mouth and face and can disrupt normal eating. In addition, certain oral diseases indicate that other health problems may be present, and may influence the development and management of chronic conditions, such as cardiovascular disease and diabetes. Hormonal changes during puberty and pregnancy may contribute to the development of gingivitis. Bone density loss later in life can lead to tooth loss.

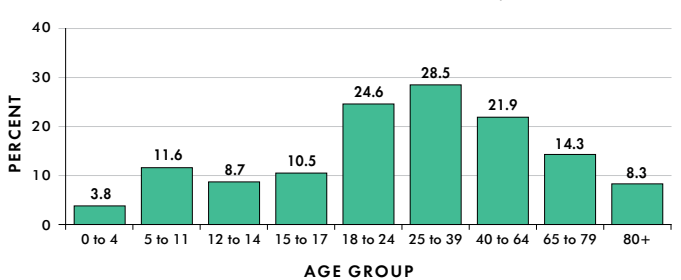
Lack of dental insurance is a barrier to adequate dental care for many California females. In 2003, 37.4 percent of Hispanic females, 33.8 percent of American Indians/Alaska Natives, 22.5 percent of Black/African Americans, 17.2 percent of Asians, and 16.3 percent of Whites aged 18 and older could not afford needed dental care.

A higher proportion of females aged 18 to 24 (24.6 percent) and 25 to 39 (28.5 percent) could not afford dental care when needed compared with females in other age groups. Lower proportions of females younger than 17 as well as females 65 and older reported need for dental care.

CALIFORNIA FEMALES WHO COULD NOT AFFORD DENTAL CARE, BY RACE/ETHNICITY, 2003
Source (II.3): California Health Interview Survey



CALIFORNIA FEMALES WHO COULD NOT AFFORD DENTAL CARE, BY AGE GROUP, 2003
Source (II.3): California Health Interview Survey



SEXUALLY TRANSMITTED DISEASE - CHLAMYDIA

Sexually transmitted diseases (STDs) are the most commonly reported communicable diseases in California.[1] STDs affect both genders, but some disproportionately affect females: females are biologically more susceptible to some diseases, and infections such as Chlamydia commonly go unrecognized and untreated because they cause fewer visible symptoms, compared with other STDs.[2] Untreated STDs are of particular concern for females because they are associated with adverse reproductive health outcomes such as pelvic inflammatory disease, infertility, and cervical cancer. Untreated STDs also increase the risk of acquiring HIV.

Chlamydia is the most commonly reported STD in California: 122,538 cases were reported in 2004.[3] Females represented 72 percent of cases and males represented 28 percent of cases, demonstrating the disproportionate impact chlamydia has on females.[4] From 1990 to 2004, females consistently had more than three times the reported rate of infection than males. This large gender difference reflects differences in health care use and access to screening, as well as transmission and acquisition rates.[5] National and statewide recommendations specifically target females age 25 years and younger for annual screening[6] because they consistently have higher rates of chlamydia than older females. Increased screening with more sensitive, non-invasive tests has contributed to increased rates for both genders during 1990-2004.[7]

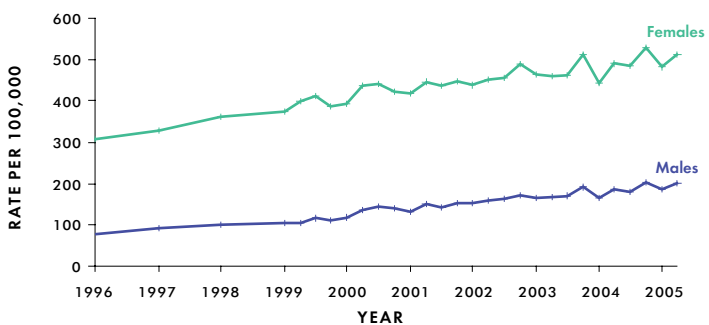
Racial/ethnic disparities in chlamydia prevalence rates are also evident. During 2004, 16.7 percent of Black/African American females aged 15 to 19 seeking care in family planning settings tested positive for chlamydia, as did 7.0

percent of Hispanics and 5.9 percent of Whites. Further analysis of different sexual risk behaviors and access to screening are warranted to explain racial/ethnic differences in these rates.

1 California Department of Health Services, Sexually Transmitted Control Branch. STD in California, 2004.
2 Cates W Jr, Wasserheit JN. Genital chlamydial infections: Epidemiology and reproductive sequelae. Am J Obstet Gynecol 1991; 164:1771-1781. Koutsky L et al. A cohort study of the risk of cervical intraepithelial neoplasia grade 2 or 3 in relation to papillomavirus infection. N Engl J Med 1992; 327:1272-8.
3 California Department of Health Services, STD Control Branch. Chlamydia, Cases and Rates, California Counties and Selected City Health Jurisdictions, 2000-2004.
4 California Department of Health Services, STD Control Branch. Chlamydia, Cases and Rates, California Counties and Selected City Health Jurisdictions, 2000-2004.
5 California Department of Health Services. Sexually Transmitted Diseases in California 2004, p. 6.
6 2006 CDC STD Treatment Guidelines; 2001 USPSTF Chlamydia Screening Guidelines.
7 Dicker LW, Mosure DJ, Levine WC, et a;. Impact of switching laboratory tests on reported trends in Chlamydia trachomatis infections. Am J Epidemiol 2000; 151:430-5.

CHLAMYDIA, RATES BY GENDER, CALIFORNIA 1996-2005*

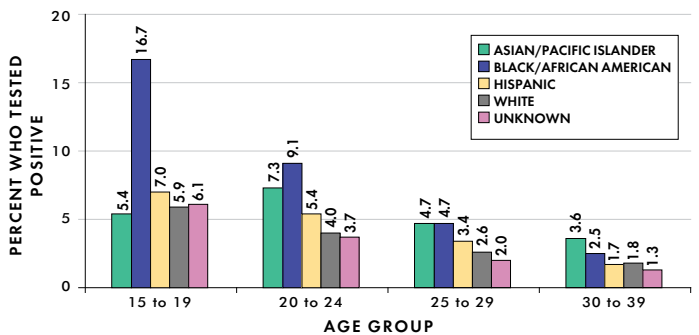
Source (II.11): California Department of Health Services, Sexually Transmitted Disease Control Branch



* Annual rates are displayed for 1996-1998. Annualized quarterly rates are displayed for 1st quarter 1999 through 2nd quarter 2005.

CHLAMYDIA PREVALENCE MONITORING, PERCENT POSITIVE FOR FEMALES AT FAMILY PLANNING CLINCS, BY AGE GROUP AND RACE/ETHNICITY, CALIFORNIA 2004

Source (II.11): California Department of Health Services, Sexually Transmitted Disease Conotrol Branch



NOTE: Native American/Alaskan Natives were excluded due to low test volume.

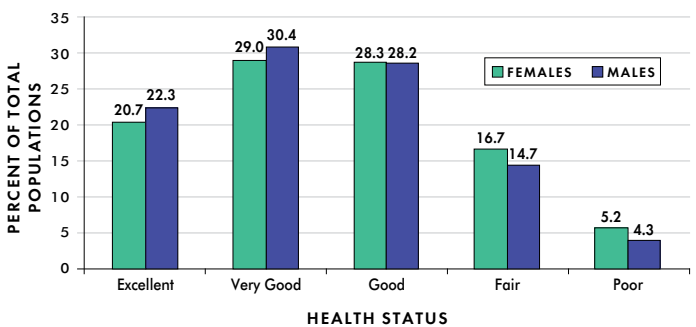
SELF-REPORTED HEALTH STATUS

In 2003, about half of both females and males reported being in excellent or very good health. Higher proportions of males reported excellent health status (22.3 percent) than females (20.7 percent). Females reported their health status as fair and poor (16.7 percent and 5.2 percent) more often than males (14.7 percent and 4.3 percent, respectively).

Health disparities for females by race/ethnicity were seen in self-reported health status. While almost half of Black/African American and Asian females reported being in excellent or very good health, a greater proportion of Whites (60.0 percent) rated their health as excellent or very good. At the other end of the spectrum, higher proportions of Hispanic females rated their health status as fair or poor (34.5 percent). In comparison, about one quarter of Asian and Black/African Americans reported their health status as fair or poor. Whites reported having fair or poor health status less frequently than all other groups (14.5 percent).

SELF-REPORTED HEALTH STATUS, BY GENDER, CALIFORNIA 2003

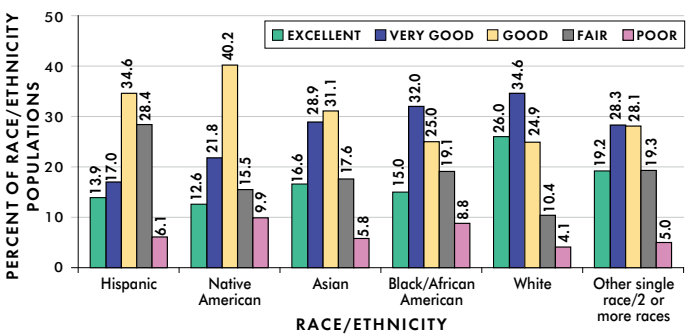
Source (II.3): California Health Interview Survey



NOTE: Each bar represents a percentage of the total population of that gender.

SELF-REPORTED HEALTH STATUS OF CALIFORNIA FEMALES, BY RACE/ETHNICITY, 2003

Source (II.3): California Health Interview Survey



NOTE: Each bar represents a percentage of the total population of that race/ethnicity group.

INJURY

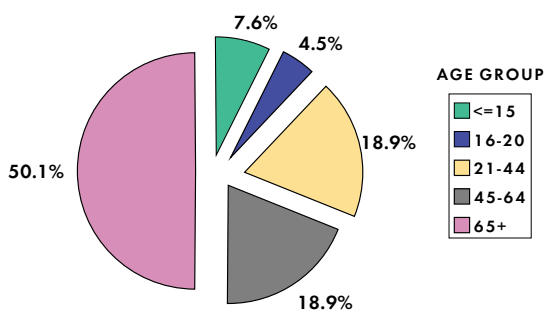
In 2003, females constituted 47.8 percent of hospital admissions for nonfatal injuries.[1] About half of these admissions were of women aged 65 and over, while most of the other admissions were equally distributed between women aged 21 to 44 and 45 to 64 years.

Falls was the most common cause of injury requiring hospitalization among both genders (51.2 percent of female hospitalizations and 31.1 percent of male hospitalizations), followed by motor vehicle crashes as an occupant (8.6 percent of female hospitalizations and 9.2 percent of male hospitalizations). The proportion of hospitalizations due to suicide by poisoning was higher for females (7.3 percent) than for males (3.4 percent).

1 *California Office of Statewide Health Planning and Development, Patient Discharge Data. http://www.applications.dhs.ca.gov/epicdata/default.htm.*

INJURY-RELATED NONFATAL HOSPITALIZATIONS, FEMALES, BY AGE GROUP,CALIFORNIA 2003

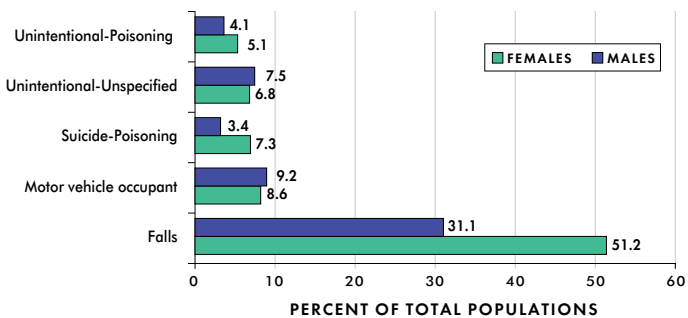
Source (II.6): California Office of Statewide Health Planning and Development, Patient Discharge Data



Prepared by: California Department of Health Services, Epidemiology and Prevention for Injury Control Branch

TOP FIVE NONFATAL INJURIES REQUIRING HOSPITALIZATION, BY GENDER, CALIFORNIA 2003

Source (II.6): California Office of Statewide Health Planning and Development, Patient Discharge Data



NOTE: Each bar represents a percentage of the total hospitalizations for that gender.

Prepared by: California Department of Health Services, Epidemiology and Prevention for Injury Control Branch

INTIMATE PARTNER VIOLENCE AND DISABILITIES

Intimate partner violence (IPV) refers to physical or emotional abuse perpetrated by a spouse or other partner, and includes physical violence, sexual abuse, threatened violence, and attempts to exert control over the victim's activities.

In 2003-2004, women responded to the California Women's Health Survey regarding their experience of IPV in the preceding year.[1] Reported levels were compared between women with and without disabilities.

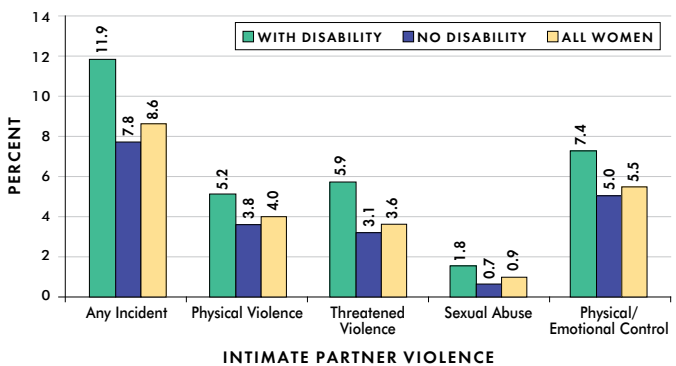
Women with disabilities were more likely than women without disabilities to experience IPV: 11.9 percent of women with disabilities reported experiencing one or more forms of IPV compared to 7.8 percent of women without disabilities. Higher proportions of California women with a disability (5.2 percent) reported physical violence than non-disabled women (3.8 percent). Nearly twice the proportion of women with disabilities reported threatened violence by an intimate partner (5.9 percent) than women without disabilities (3.1 percent). Among women under 65 years, those with disabilities were more than twice as likely to have

experienced sexual abuse (1.8 percent) than their non-disabled counterparts (0.7 percent).

1 *Kaye H.S. 2006. Issue 4, Number 29: Intimate Partner Violence Against Women with Disabilities in California, 2003-2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main_cwhs/wmns_hlth_survey/survey.htm.*

CALIFORNIA WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE OR ABUSE DURING PRECEDING YEAR, BY DISABILITY STATUS, 2003-2004

Source (II.1): California Women's Health Survey



Prepared by: California Department of Health Services, Epidemiology and Prevention for Injury Control Branch and Institute for Health and Aging, University of California, San Francisco

INTIMATE PARTNER VIOLENCE AND MENTAL HEALTH

Intimate partner violence (IPV), often called domestic violence, adversely affects both the individual and the family. Women who experience IPV are burdened by its impact on their safety, relationships, families, finances, and mental and physical health.[1]

During 2003-2004, women responded to the California Women's Health Survey regarding their experience of IPV in the past year.[2] Women were also asked about the number of days in the past month that their mental health was not good. If they reported 14 or more such days, they were considered to have "frequent mental distress" (FMD).[3] The proportion of women who had FMD and desired mental health services varied depending on whether they had experienced physical IPV, psychological-only IPV, or neither.[4] Women who experienced physical IPV had nearly three times the rates of having FMD and desiring mental health services compared with women who had not experienced IPV. Of the women who experienced both physical IPV and FMD, 71.5 percent wanted mental health help, but less than half (46.5 percent) reported receiving it. These figures demonstrate that many women experiencing IPV are not receiving the mental health help they desire.

1 *National Center for Injury Prevention and Control. 2003. Costs of intimate partner violence against women in the United States. Atlanta: Centers for Disease Control and Prevention.*

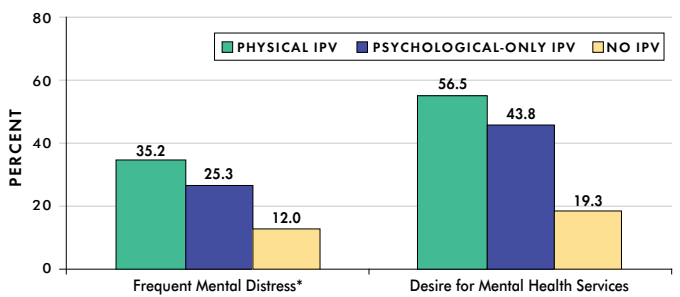
2 *Libet M, Weinbaum, Z. 2006. Issue 4, Number 28: Frequent Mental Distress and Desire for Help Among California Women Experiencing Intimate Partner Violence, 2003-2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

3 *CDC. Self-reported frequent mental distress among adults – United States, 1993-1996. MMWR 1998, 47(16): 325-331.*

4 *Psychological-only IPV – defined as a "yes" response to any question about whether the respondent was frightened, felt controlled, or followed by an intimate partner (excluding respondents who also reported physical IPV).*

PROPORTION OF FREQUENT MENTAL DISTRESS* AND DESIRE FOR MENTAL HEALTH SERVICES BY TYPE OF INTIMATE PARTNER VIOLENCE (IPV), CALIFORNIA WOMEN, 2003-2004

Source (II.1): California Women's Health Survey



*14 or more days reported of "not good mental health" in the past month

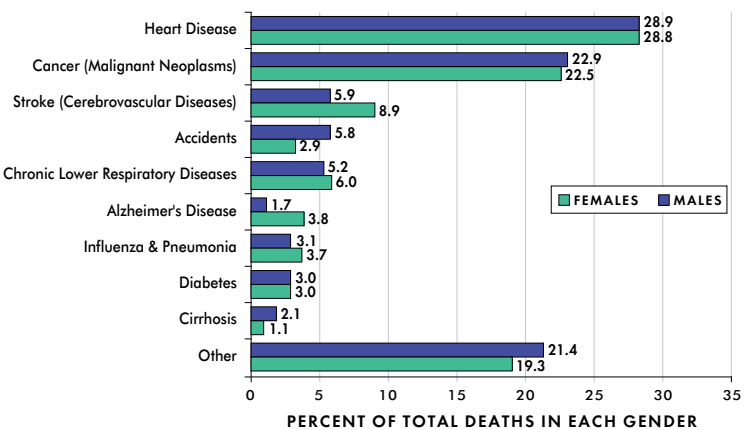
LEADING CAUSES OF DEATH

Females are disproportionately affected by several diseases, including stroke, chronic lower respiratory diseases, and Alzheimer's disease. There were 119,164 female deaths in 2003 in California.[1] Heart disease, cancer (malignant neoplasm), and stroke (cerebrovascular disease) were the leading causes of death for both males and females.

Significant variability was seen in death rates by race and ethnicity.[2] In 2000, Black/African American females died from stroke, heart disease, and cancer at higher rates than did all other racial/ethnicity groups.

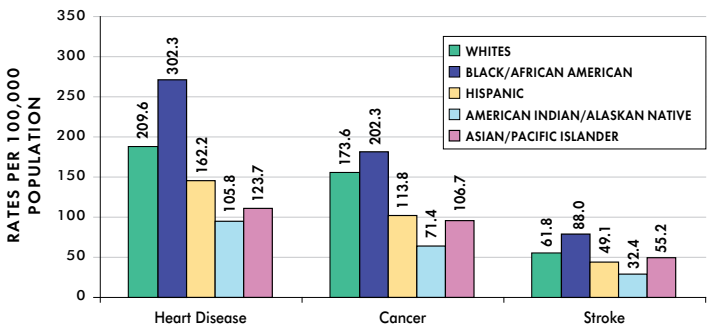
1 *California Department of Health Services. Death Records, 2003.*
2 *Women's Health and Mortality Chartbook. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, California 2000.*

LEADING CAUSES OF DEATH IN CALIFORNIA, BY GENDER, 2003
Source (II.7): California Department of Health Services, Death Records



NOTE: Each bar represents a percentage of the total population of that gender.

MAJOR CAUSES OF DEATH* AMONG CALIFORNIA FEMALES, 2000
Source (II.8): Women's Health and Mortality Chartbook



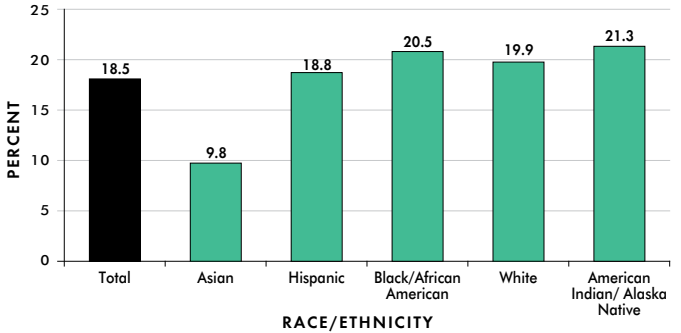
* Rates are age-adjusted and for all ages unless noted.

MENTAL HEALTH

According to the 2001 California Health Interview Survey, females were more likely than males to report needing help for an emotional/mental problem (18.5 percent versus 11.6 percent). Disparities were evident among females of different race/ethnicity. Higher percentages of American Indian/ Alaska Native (21.3 percent), Black/African American (20.5 percent), White (19.9 percent), and Hispanic (18.8 percent) females reported needing help for an emotional/mental health problem than did Asians (9.8 percent).

CALIFORNIA FEMALES NEEDING HELP FOR EMOTIONAL/MENTAL HEALTH PROBLEMS, BY RACE/ETHNICITY 2001

Source (II.9): California Health Interview Survey



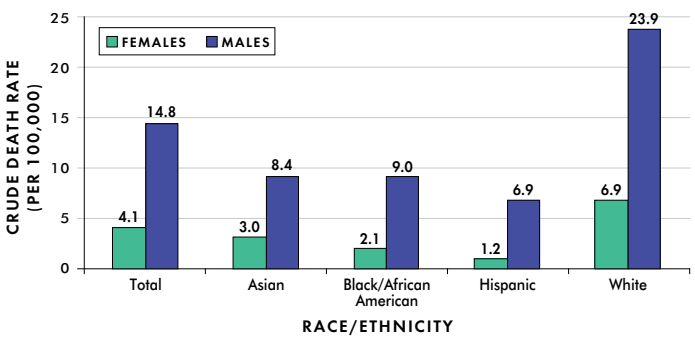
SUICIDE

Suicide has been related to multiple risk factors, including variables of gender and race/ethnicity. Persons who commit suicide often suffer from depression or other diagnosable mental or substance abuse disorders.[1] In 2003, 733 females and 2,663 males committed suicide.[2] California males had a crude death rate of 14.8 per 100,000, which was 3.6 times higher than the crude death rate of females (4.1 per 100,000).[2] Among females, Whites had the highest suicide rate (6.9 percent), followed by Asians (3.0 percent), Blacks/African Americans (2.1 percent), and Hispanics (1.2 percent).

Males and females tend to differ in the ways they commit suicide. During 2003 in California, the largest proportion of suicides was committed by firearms for males (50.2 percent) and by poisoning for females 43.0 percent, followed by firearms for females (22.9 percent).[2]

1 *National Institute of Mental Health. Suicide. In Harm's Way: Suicide in America. NIH Publication No. 03-4594. 2003.*
2 *California Department of Health Services. Center for Health Statistics: Suicide Deaths California, 2000-2003.*

SUICIDE CRUDE DEATH RATES (PER 100,000), BY GENDER AND RACE/ETHNICITY, CALIFORNIA 2003
Source (II.10): California Department of Health Services, Center for Health Statistics






HEALTH STATUS

REPRODUCTIVE/MATERNAL HEALTH

- BREASTFEEDING
- CONTRACEPTION
- INFERTILITY
- LIVE BIRTHS
- POSTPARTUM DEPRESSION
- PREGNANCY-RELATED MORTALITY
- PRENATAL CARE
- TEEN BIRTHS

BREASTFEEDING

Scientific research indicates that breastfeeding, and specifically exclusive breastfeeding, is the superior mode of infant feeding, providing both health and economic benefits. Breastfeeding enhances the health, growth, immunity, and development of infants. Breastfeeding may reduce the risk of ovarian and breast cancer in mothers and delay loss of bone strength.[1]

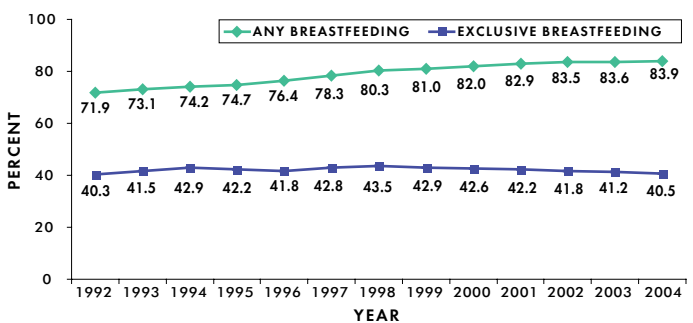
Although California data indicated a steady increase in the rates of breastfeeding from 71.9 percent in 1992 to 83.9 percent in 2004, exclusive breastfeeding rates remained the same (40.3 in 1992 to 40.5 in 2004).[2]

Significant disparities in rates of initiating breastfeeding exist between different racial/ethnicity groups in California. In 2004, rates for in-hospital breastfeeding ranged from a high of 87.2 percent (for any breastfeeding) and 61.8 percent (for exclusive breastfeeding) among White infants to a low of 68.3 percent (for any breastfeeding) and 27.4 percent (for exclusive breastfeeding) among Pacific Islander infants. Additionally, although Hispanic infants had one of the highest rates of any breastfeeding (83.6 percent), their exclusive breastfeeding rates were among the lowest of the seven racial/ethnicity

groups analyzed (29.0 percent).

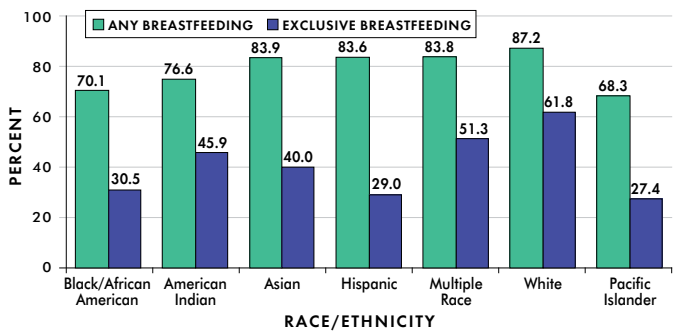
1 *American Academy of Pediatrics, Section on Breastfeeding. Breastfeeding and the use of human milk. Pediatrics 2005; 115(2): 469-506.*
2 *Any breastfeeding signifies the infant was fed a combination of breast milk and formula in the period from birth through hospital discharge. Exclusive breastfeeding signifies the infant was only fed breast milk during this same period.*

CALIFORNIA IN-HOSPITAL BREASTFEEDING, 1992-2004
Source (II.15): California Department of Health Services, Genetic Disease Branch, Newborn Screening Database



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health / Office of Family Planning Branch

CALIFORNIA BREASTFEEDING, BY INFANT RACE/ETHNICITY, 2004
Source (II.15): California Department of Health Services, Genetic Disease Branch, Newborn Screening Database



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health / Office of Family Planning Branch

CONTRACEPTION

Contraception use is essential among sexually active women of reproductive age who wish to limit their number of children.[1] Family planning is one of the 28 focus areas of Healthy People 2010, a nationwide comprehensive health promotion and disease prevention agenda launched by the U.S. Department of Health and Human Services.[2]

In 2003-2004, California Women's Health Survey participants aged 18-44 were asked questions about their risk of an unintended pregnancy.[1] "At risk" was defined as sexually active in the past 12 months and not pregnant, sterilized, postpartum, seeking pregnancy, or infertile. The results showed that about half of women aged 18 to 44 years were at risk for an unintended pregnancy in 2003-2004. [1] Contraception was used by most women 18 to 44 years of age at risk of an unintended pregnancy. Most women using contraception used an oral contraceptive pill, patch, or ring (29.6 percent). Sterilization (either by women or their partners) was the second most common method of contraception for women (16.6 percent relied on female sterilization and 12.1 percent on male sterilization). One quarter of women relied on their partners using condoms to prevent unplanned

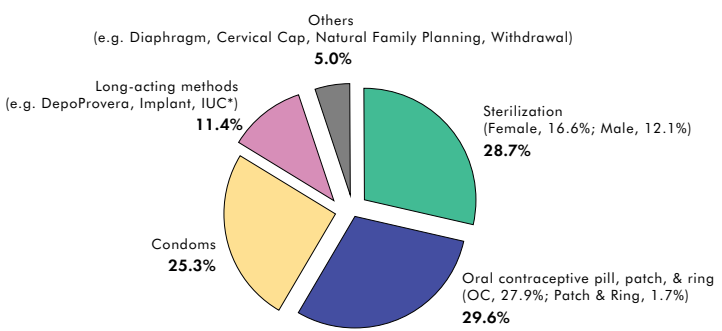
pregnancy. The least common methods, including using a diaphragm and natural family planning, were used by only 5 percent of women. Of those at risk for unintended pregnancy, 13.6 percent used no form of contraception.

The use of different contraceptive methods varied across racial and ethnic groups. White women preferred oral contraception (41.0 percent), Hispanic women predominantly used oral contraception or relied on their partners using condoms (28.0 percent each), and Asian/Others and Black/African American women preferred condom use (40.0 percent and 41.0 percent, respectively). Black/African Americans and Hispanics were more likely than other groups not to use a contraceptive method (16.0 percent for both), but all groups reported some level of not using contraception.

1 *Chabot M, Bradsberry M. 2006. Issue 4, Number 17: Contraceptive Use Among California Women Ages 18-44, 2003-2004. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

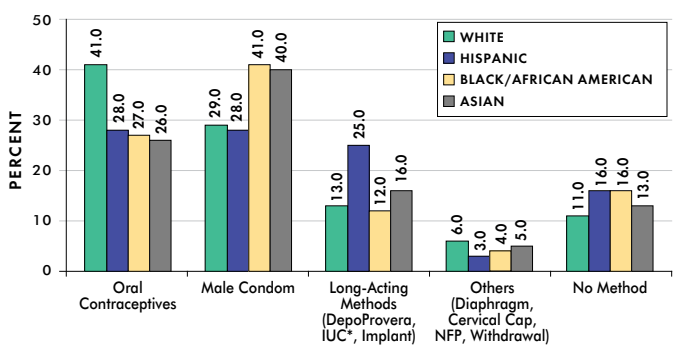
2 *U.S. Department of Health and Human Services. 2000. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: U.S. Government Printing Office.*

CALIFORNIA WOMEN 18-44 CURRENTLY USING A METHOD OF CONTRACEPTION, 2003-2004
Source (II.1): California Women's Health Survey



* - Intrauterine Contraceptive

METHODS OF CONTRACEPTION USED BY CALIFORNIA WOMEN AGES 18-44 AT RISK OF UNINTENDED PREGNANCY, 2003-2004
Source (II.1): California Women's Health Survey



* - Intrauterine Contraceptive

INFERTILITY

A couple is defined as infertile if they do not use contraception and the woman has not become pregnant for 12 months or more.[1] In 2002, 7.4 percent of U.S. married women aged 15 to 44 were infertile.[1]

In 2003, California Women's Health Survey participants aged 18 to 50 years were asked the following questions: "In the past have you ever tried for more than 12 months to get pregnant and weren't successful?" (defined as having "problems getting pregnant") and "Have you ever been told by a doctor or other health professional that you were infertile?"[2] Responses were stratified by age and race/ethnicity.

Of the respondents, 11.2 percent reported having problems getting pregnant after 12 months of trying, and 4.6 percent reported having been diagnosed with infertility.[2] Women aged 35 to 50 years were more likely to report problems with conception than women aged 18 to 34.

Whites (13.7 percent) were more likely to report problems getting pregnant than Hispanics (8.3 percent), Black/African Americans (7.0 percent), and Asians/Others (9.8 percent). Black/African Americans were more likely to report having been diagnosed with infertility (9.1 percent) than Whites (5.3

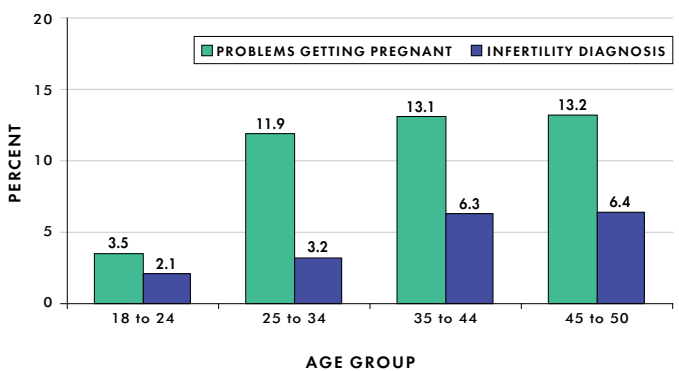
percent), Asians/Others (3.0 percent), and Hispanics (2.9 percent).

1 *Centers for Disease Control and Prevention (CDC). Fertility, family planning and reproductive health of U.S. women: data from the 2002 national Survey of Family Growth. http://www.cdc.gov/nchs/data/series/sr_23/sr23_025.pdf.*

2 *Chow J, Lifshay J, Bolan G, Webb A. 2006. Issue 4, Number 20: Infertility: Problems Getting Pregnant and Past Infertility Diagnosis Among California Women, 2003. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

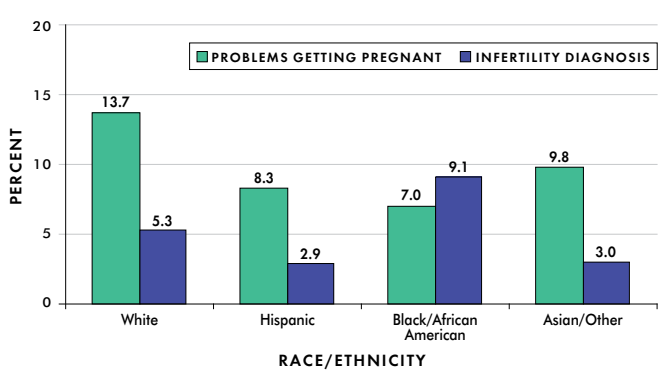
PROBLEMS GETTING PREGNANT AND PAST INFERTILITY DIAGNOSIS, BY AGE GROUP, CALIFORNIA 2003

Source (II.1): California Women's Health Survey



PROBLEMS GETTING PREGNANT AND PAST INFERTILITY DIAGNOSIS, BY RACE/ETHNICITY, CALIFORNIA 2003

Source (II.1): California Women's Health Survey



LIVE BIRTHS

In 2004 there were 544,685 resident live births in California, an increase from 531,285 in 2000.[1] The fertility rate in California decreased slightly from 70.0 live births per 1,000 females in 2000 to 69.3 per 1,000 females in 2004.[2,3]

In 2004, 87.2 percent of California births were to females between the ages of 20 to 39. Females 25 to 29 years accounted for the largest percent of resident births (26.0 percent), and those 40 years of age and older accounted for the smallest share of births (3.5 percent). Females younger than 20 years accounted for 9.3 percent of births.

From 2000 through 2004, fertility rates decreased for most racial/ethnic groups, including Hispanics (from 95.9 to 88.6 per 1,000), American Indians (from 43.6 to. 32.7 per 1,000), Black/African Americans (from 62.4 to 51.6 per 1,000), and Pacific Islanders (from 82.7 to 78.5 per 1,000). Racial/ethnic groups that had increased fertility rates were Whites (53.1 to 55.5 per 1,000), Asians (62.6 to 66 per 1,000), and multi-racial females (44.9 to 46.8 per 1,000).[2]

In 2004, more than half of resident births were to Hispanic females. Whites had 29.2 percent of resident births, Asians had 11.4 percent, Black/African Americans had 5.3 percent,

multi-racial women had 1.3 percent, and Pacific Islander and American Indians had less than 1 percent of births.

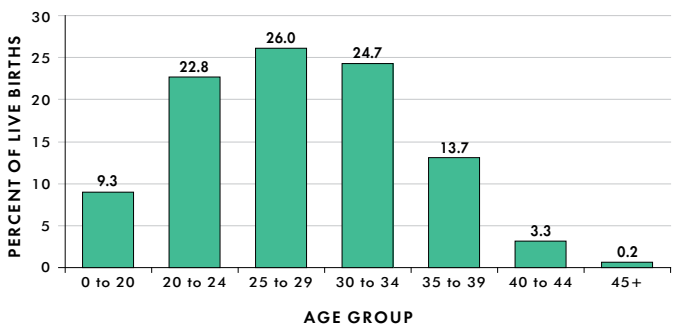
1 *Center for Health Statistics, Office of Health Information and Research, Data Table VSCA 02-01: TABLE 2-1. LIVE BIRTHS BY AGE OF MOTHER, CALIFORNIA, 1960-2004 (By Place of Residence) http://www.dhs.ca.gov/hisp/chs/OHIR/tables/datafiles/vsofca/0201.pdf. Accessed April 21, 2006*

2 *Center for Health Statistics, Office of Health Information and Research, Data Table VSCA 02-02: TABLE 2-2. GENERAL FERTILITY RATES, TOTAL FERTILITY RATES, AND BIRTH RATES BY AGE AND RACE/ETHNIC GROUP OF MOTHER, CALIFORNIA, 2000-2004 (By Place of Residence) http://www.dhs.ca.gov/hisp/chs/OHIR/tables/datafiles/vsofca/0202.pdf. Accessed April 21, 2006.*

3 *The general fertility rate is defined as live births per 1,000 females of childbearing age (15-44 years old).*

CALIFORNIA RESIDENT LIVE BIRTHS, BY MATERNAL AGE GROUP, 2004

Source (II.12): California Department of Health Services, Birth Statistical Master File

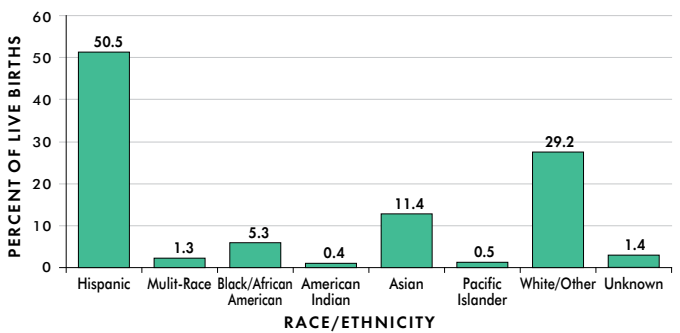


NOTE: Each bar represents a percentage of the total population of resident live births.

Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch

CALIFORNIA RESIDENT LIVE BIRTHS, BY MATERNAL RACE/ETHNICITY, 2004

Source (II.12): California Department of Health Services, Birth Statistical Master File



NOTE: Each bar represents a percentage of the total population of resident live births.

Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch

POSTPARTUM DEPRESSION

Depression is the leading cause of disease-related disability among women, particularly women of childbearing age.[1] Pregnancy and new motherhood may increase a woman's risk for depression, which also has consequences for her children and family. The exact prevalence of postpartum depression in the United States is not known, but it is estimated that between 6.5 and 12.9 percent of mothers experience major or minor depression during the year after giving birth.[1]

The Maternal and Infant Health Assessment surveyed a representative sample of females delivering live births in California using the Iowa short form of the Center for Epidemiologic Studies Depression Scale (CES-D) to assess the association between high postpartum depression screening scale scores and demographic and health-related measures.[2,3] The CES-D is a self-report scale requiring the participant to indicate the frequency of her feelings or behaviors previously found to be related to postpartum depression during the past week.

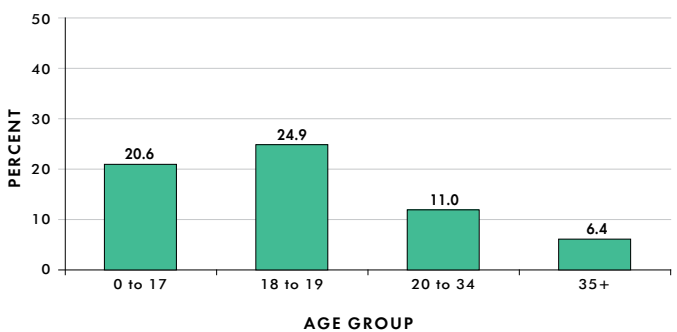
Respondents in the top 12 percent of the depression screening scores were considered at increased risk for

postpartum depression. Results from 2004 indicated that younger females were most at risk for postpartum depression: females 19 and younger had rates of risk for postpartum depression of more than 20 percent; women 35 and older had the lowest rate (6.4 percent). Risk of postpartum depression varied by postpartum health insurance status, with uninsured women being at higher risk. Postpartum women who are young or without health insurance might benefit from screening, counseling, diagnosis, and treatment for depression.

1 *Agency for Health care Research and Quality. http://www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridep.pdf.*
2 *Maternal and Infant Health Assessment (MIHA) survey is a collaborative project of the California Department of Health Services/Maternal, Child and Adolescent Health/Office of Family Planning Branch and researchers in the Department of Family and Community Medicine at the University of California at San Francisco.*
3 *Radloff, LS. The CES-D scale: A self-report depression scale for research in the general population. Applied Psychological Measurement. 1977 (1):385-401.*

CALIFORNIA WOMEN REPORTING HIGH FREQUENCY OF POSTPARTUM DEPRESSION SYMPTOMS, BY AGE GROUP, 2004

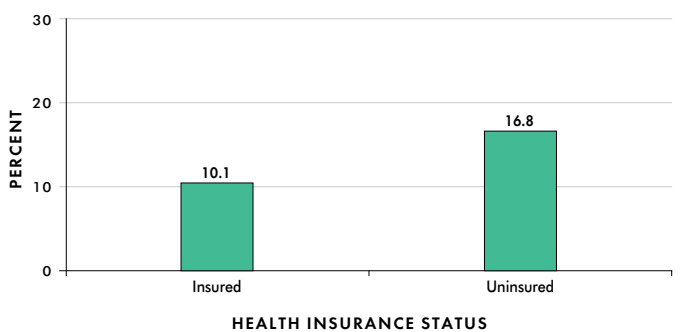
Source (II.16): Maternal and Infant Health Assessment



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch

CALIFORNIA WOMEN REPORTING HIGH FREQUENCY OF POSTPARTUM DEPRESSION SYMPTOMS, BY POSTPARTUM HEALTH INSURANCE STATUS, 2004

Source (II.16): Maternal and Infant Health Assessment



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch

PREGNANCY-RELATED MORTALITY

Maternal mortality is defined in the International Classification of Diseases Ninth Revision (ICD-9) as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by pregnancy or its management but not from accidental or incidental causes."[1] Beginning with deaths occurring in 1999, the International Classification of Diseases Tenth Revision (ICD-10) expanded on this definition to include deaths that occur within an entire year after the termination of pregnancy.[1] Following the recommendations of the American College of Obstetricians and Gynecologists/Centers for Disease Control Maternal Mortality Study Group, we call these pregnancy-related deaths.[1]

California data indicate that the rate of pregnancy-related deaths has increased from 8.3 deaths per 100,000 live births in 1999 to 13.6 births per 100,000 in 2004. Black/African American women had the highest pregnancy-related mortality (37.6 per 100,000 live births) during 2002-2004, and Hispanics and Whites had 12.0 deaths per 100,000. During 1999-2004, pregnancy-related mortality rates for Black/African American

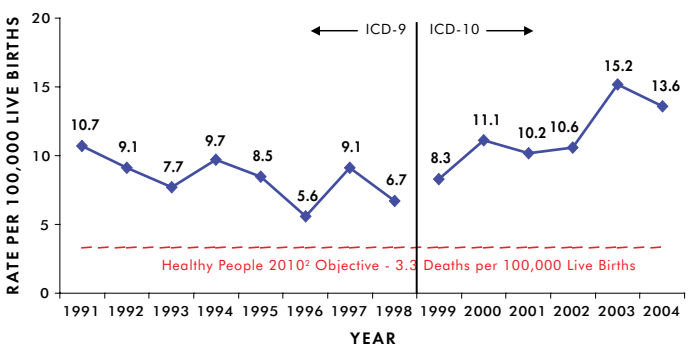
women increased at a faster rate than Hispanic and White pregnancy-related mortality rates. The conversion from ICD-9 to ICD-10 coding of death certificates explains only a small part of the recent increase in pregnancy-related mortality.

1 *Centers for Disease Control and Prevention. (2001). Strategies to reduce pregnancy-related deaths. Retrieved April 28, 2006, from http://www.cdc.gov/reproductivehealth/ProductsandPubs/PDFs/Strategies_taged.pdf.*

2 *U.S. Department of Health and Human Services. 2000. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: http://www.healthypeople.gov/document/html/volume2/19nutrition.htm.*

PREGNANCY-RELATED MORTALITY RATE, CALIFORNIA RESIDENTS, 1991-2004

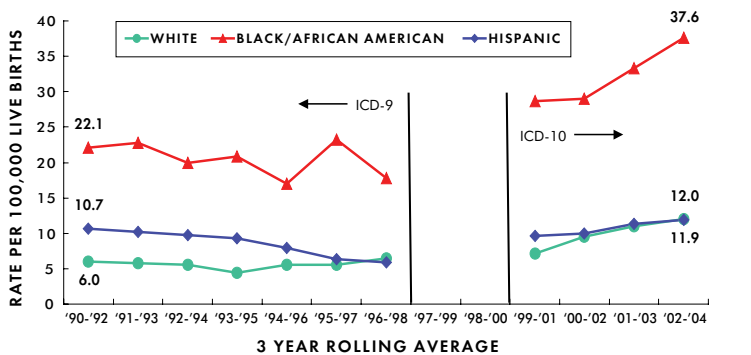
Source (II.17): California Department of Health Services, Birth Statistical Master File, Death Statistical Master File



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health / Office of Family Planning Branch

PREGNANCY-RELATED MORTALITY RATE, BY RACE/ETHNICITY, CALIFORNIA RESIDENTS, 1990-2004

Source (II.17): California Department of Health Services, Birth Statistical Master File, Death Statistical Master File



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health / Office of Family Planning Branch

PRENATAL CARE

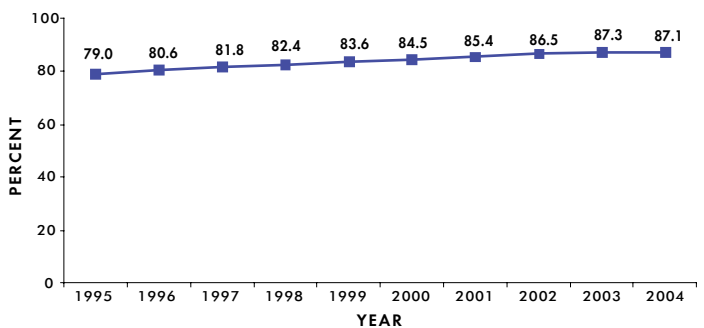
Prenatal care is important for achieving healthy pregnancy outcomes. Early prenatal care tends to reduce the incidence of perinatal illness, disability, and death by providing health care advice to mothers and identifying and managing chronic or pregnancy-related risks.

In California, the percentage of women initiating prenatal care during the first trimester has increased from 79.0 percent in 1995 to 87.1 percent in 2004. This positive trend demonstrates progress toward meeting the Healthy People 2010 objective of 90 percent of women initiating prenatal care during the first trimester.

Even though the majority of women receive prenatal care during their first trimester, racial/ethnic disparities are evident. In 2004, lower proportions of American Indian and Pacific Islander women initiated first trimester prenatal care (76.3 percent and 74.3 percent, respectively) compared with other race/ethnic groups. Conversely, White/Other women (90.8 percent) initiated prenatal care during their first trimester, above the Healthy People 2010 objective.

CALIFORNIA FIRST TRIMESTER PRENATAL CARE INITIATION, 1995-2004

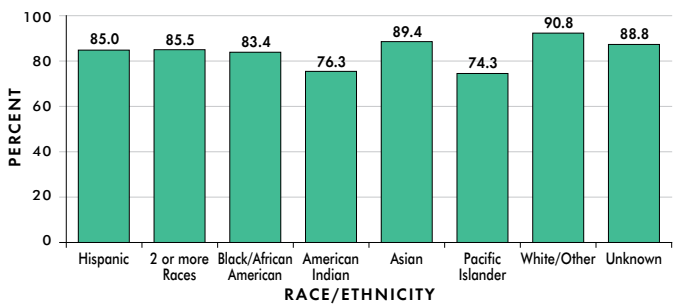
Source (II.12): California Department of Health Services, Birth Statistical Master File



Prepared by: California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch

CALIFORNIA FIRST TRIMESTER PRENATAL CARE INITIATION, BY RACE/ETHNICITY, 2004

Source (II.12): California Department of Health Services, Birth Statistical Master File



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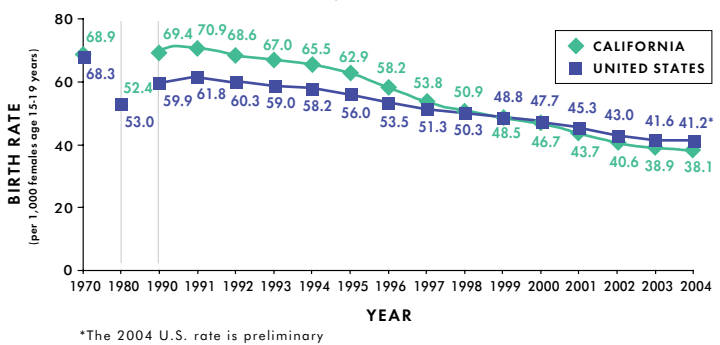
TEEN BIRTHS

California's teen (ages 15-19) birth rate has declined 46.3 percent since its peak in 1991, from 70.9 per 1,000 females in 1991 to 38.1 per 1,000 females in 2004. California's teen birth rate fell below the national rate in 1999 and has remained lower, with California's 2004 rate at 38.1 per 1,000 females compared to the U.S. rate of 41.2.

California's recent decline in birth rate to teens is seen in all major racial/ethnic groups. In 2004, Hispanics had the highest teen birth rate (64.3 per 1,000). Black/African Americans had the second highest rate (37.3 per 1,000) followed by multiple-race teens (22.8 per 1,000), and American Indian/Aleut/Eskimos (20.9 per 1,000). Whites and Asian/Pacific Islanders had the lowest teen birth rates (16.7 and 12.2 per 1,000, respectively).

CALIFORNIA AND U.S. TEEN BIRTH RATES FOR VARIOUS YEARS, 1970-2004

Source (II.13): California Department of Health Services, Birth Statistical Master Files, California Department of Finance, Population Profection Files



*The 2004 U.S. rate is preliminary

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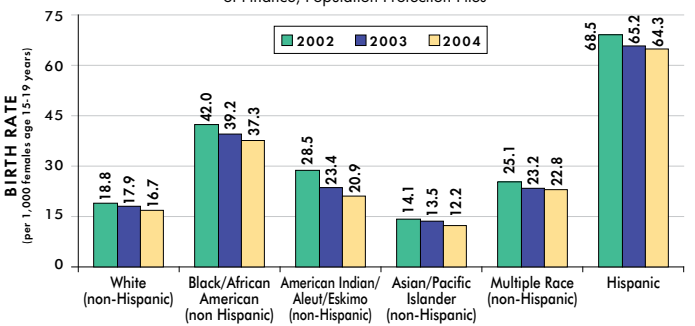
CALIFORNIA TEEN BIRTH RATES, BY RACE/ETHNICITY AND YEAR, 2002-2004

Source (II.14): California Department of Health Services, Birth Statistical Master Files, California Department of Finance, Population Profection Files



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HEALTH STATUS

SPECIAL POPULATIONS

- BORDER HEALTH
- WOMEN 65 AND OLDER
- HOUSING INSECURITY
- HUMAN TRAFFICKING VICTIMS

BORDER HEALTH

The California-Mexico border is an area of intense human contact and movement. The border area is defined as the area within 62 miles of either side of the actual border and includes San Diego and Imperial Counties in California and the Mexican state of Baja California.[1] Imperial County has the highest percentage of Hispanic residents in California (70 percent). Both Imperial and San Diego Counties are federally designated as partial county health professional shortage areas for primary medical care services.[1]

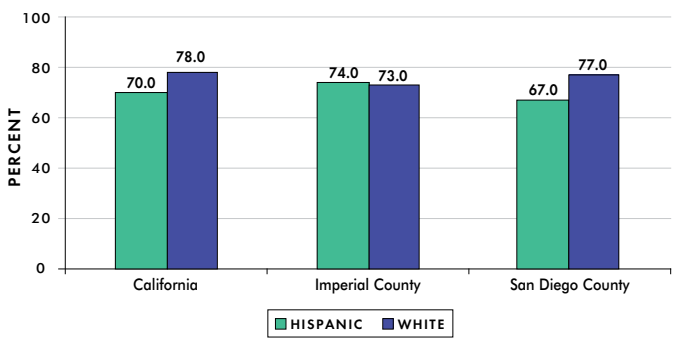
Several health care indicators highlight disparities between White and Hispanic women in the border area. In addition to having less access to health care than Whites, Hispanic women in California were also less likely to have had a mammogram in the past two years (70.0 percent of Hispanics vs. 78.0 percent of Whites).[2] Mammography rates in Imperial County were similar for White and Hispanic women, but in San Diego County, Hispanic women were less likely to have been screened for breast cancer than Whites (67.0 percent vs. 77.0 percent, respectively). During 2001-2003, a lower proportion of Hispanic mothers in California received early prenatal care (83.9 percent) than did White

mothers (90.5 percent). Hispanic mothers in Imperial County received early prenatal care at lower rates than did Hispanic mothers in San Diego County (75.6 percent vs. 82.0 percent, respectively).

1 *California Department of Health Services. Office of Binational Border Health. Annual Border Health Status Report, 2000. http://www.dhs.ca.gov/ps/dcdc/COBBH/default.htm.*
2 *California Health Interview Survey (CHIS). http://www.chis.ucla.edu/.*

PROPORTION OF HISPANIC AND WHITE WOMEN AGES 40 AND OLDER WITH MAMMOGRAMS IN PAST TWO YEARS, BY STATE AND BORDER COUNTY, CALIFORNIA 2003

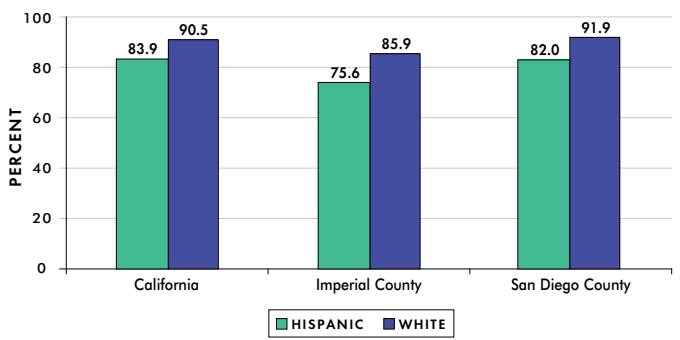
Source (II.3): California Health Interview Survey



Prepared by: California Department of Health Services, Office of Binational Border Health

PROPORTION OF HISPANIC AND WHITE MOTHERS RECEIVING EARLY PRENATAL CARE, BY STATE AND BORDER COUNTY, CALIFORNIA 2001-2003

Source (II.19): California Department of Health Services, Center for Health Statistics



Prepared by: California Department of Health Services, Office of Binational Border Health

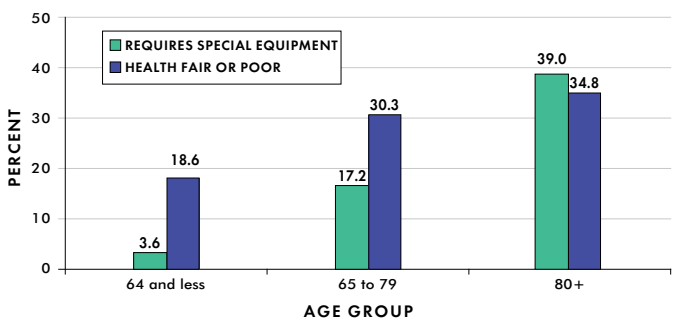
WOMEN AGED 65 AND OLDER

As women age, they tend to report a decline in health and more use of health-related special equipment. In 2001, the California Health Interview Survey asked whether women were using special equipment "such as a cane, a wheelchair, a special bed or a special telephone."[1] The need for special equipment increased to nearly 40 percent for women aged 80 and above. Women aged 80 and above reported the highest proportion of having only fair or poor health (34.8 percent) compared to women 64 and younger (3.6 percent).

The leading causes of death differed by age and race/ethnicity.[2] Heart disease, cancer, and cerebrovascular disease were the three leading causes of death for all ethnic groups. Diabetes was the fourth leading cause of death for all the race/ethnicity groups except White women. Alzheimer's disease was the fifth leading cause of death for Whites, but it was the seventh leading cause of death for the remaining race/ethnicity groups.

1 California Health Interview Survey (CHIS). AskCHIS. http://www.chis.ucla.edu/.
2 California Department of Health Services. http://www.dhs.ca.gov/hisp/chs/OHIR/tables/death/causes.htm.

PROPORTION OF WOMEN REQUIRING SPECIAL EQUIPMENT OR HAVING FAIR OR POOR HEALTH, BY AGE GROUP, CALIFORNIA 2001
Source (II.3): California Health Interview Survey



RANK OF LEADING CAUSES OF DEATH AMONG WOMEN AGED 65 AND OLDER, BY RACE/ETHNICITY, CALIFORNIA 2003
Source (II.7): California Department of Health Services, Death Records

	WHITE	BLACK/AFRICAN AMERICAN	HISPANIC	ASIAN
Heart Disease	1	1	1	1
Cancer (Malignant Neoplasms)	2	2	2	2
Cerebrovascular Disease	3	3	3	3
Chronic Lower Respiratory Disease	4	6	6	6
Alzheimer's Disease*	5	7	7	7
Influenza and Pneumonia	6	5	5	5
Diabetes	7	4	4	4

* This table combines death information of 7 leading causes of death for three age groups: 65 to 74 years, 75 to 84 years and 85 and over. Alzheimer's disease was not in the top 7 leading causes of death for the 65 to 74 age group, so Alzheimer's disease death information is available only for the 75+ age groups.

HOUSING INSECURITY

It is difficult to estimate the number of homeless individuals because of the transient nature of this population. California estimates based on continuum-of-care plans indicate that during 1996-1997 about 361,000 people, representing 1.1 percent of the state population, were homeless.[1]

In 2004, the OWH sponsored questions in the annual California Women's Health Survey asking respondents about their risk for housing insecurity. The survey defined women at risk as responding "Yes" to any of the following questions: *1) "In the past 12 months, has your household been more than 30 days late paying rent or mortgage?"; 2) "In the past 12 months, have you been without your own housing for any period of time?"; and for those who said that they moved more than once in the past 12 months, 3) "...have you had trouble finding safe, adequate, or affordable housing?"*[2]

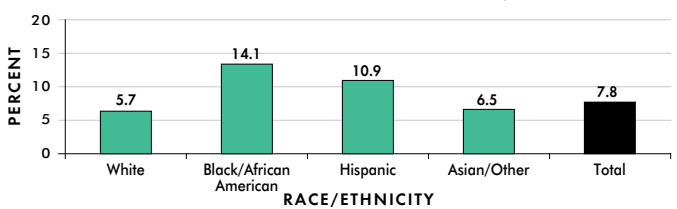
Of respondents aged 18 and older, 7.8 percent (estimated to represent 950,000 California women) reported that they experienced housing insecurity in 2003.[2] Housing insecurity affects children as well: 64.3 percent of women who experienced it reported having children under age 18 in their households. Women younger than 44, or women who were Black/African American or Hispanic were more likely to report housing insecurity than women 45 and older and women of the remaining race/ethnicity groups.

1 *California Department of Housing and Community Development (HCD). California's housing markets, 1990-1997. 1998. pp 120-127.*

2 *Weinbaum Z, Thorfinnson T, Induni M. 2006. Issue 4, Number 4: Risk for Housing Insecurity (HI) Among California Women, 2003. In California Department of Health Services, California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.*

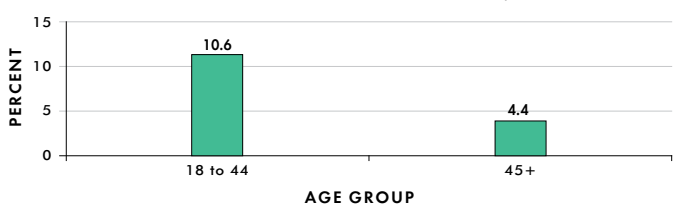
CALIFORNIA WOMEN REPORTING HOUSING INSECURITY, BY RACE/ETHNICITY, 2003

Source (II.1): California Women's Health Survey



CALIFORNIA WOMEN REPORTING HOUSING INSECURITY, BY AGE GROUP, 2003

Source (II.1): California Women's Health Survey



HUMAN TRAFFICKING VICTIMS

Trafficking is the recruitment and transportation of persons within or across international boundaries by force, fraud, or deception for the purpose of exploiting them.[1] Once they reach their destinations, trafficked people are coerced into a modern form of slavery or forced labor. The federal Trafficking Victims Protection Act of 2000 addresses sex trafficking and labor trafficking. Worldwide, 600,000 to 800,000 victims are trafficked annually across international borders, and 15,000 to 18,000 are trafficked into the United States.[1] California is one of the states most affected by human trafficking.[2] In 2004, 70 percent of people trafficked into California were estimated to be women.[1]

Although the true extent of human trafficking in California is difficult to determine, over 80 percent of documented human trafficking cases in California have been in the urban centers of Los Angeles, San Diego, San Francisco, and San Jose.[2] Between 1998 and 2003, 57 human trafficking operations were identified in almost a dozen cities, involving more than 500 individuals from 18 counties.[2] Those operations included prostitution and sex service (47.4 percent of reported victims), domestic work (33.3 percent), mail-order bride service (5.3 percent), sweatshops (5.3 percent) and agriculture (1.8 percent).[2]

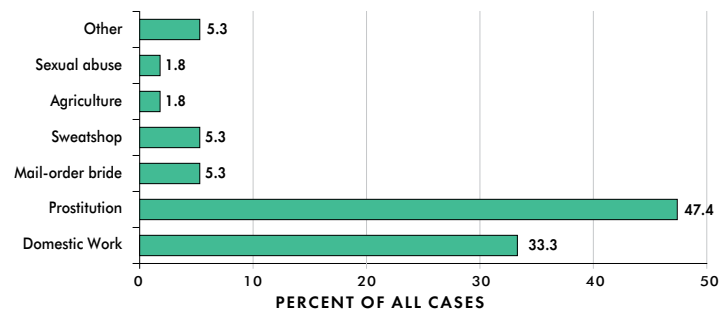
In 2004, the Coalition to Abolish Slavery & Trafficking (CAST), a California based non-profit organization, opened the first shelter for trafficked persons. CAST and other statewide partners are working to expand housing and other critical services as cases of human trafficking continue to grow in California.[3] During 2004, 52 percent of CAST clients were referred by community-based organizations, 29 percent from law enforcement agencies, and 13 percent from "Good Samaritans."[1] Thailand was the country of origin for 36 percent of CAST's clients, 17 percent were from Mexico, and 12 percent were from Indonesia.[1] Forty percent were 20 to 29 years of age and 35 percent were 30 to 39 years of age.[1] Nearly two thirds of victims were trafficked for domestic service (32 percent) and sex trafficking (32 percent).[1] Another 24 percent were trafficked for construction.[1]

Due to years of abuse and neglect, trafficking victims tend to have severe physical and mental health problems during and after their enslavement. Problems include cancer, diabetes, visual and dental problems, sexually transmitted

diseases, HIV/AIDS, and mental health issues (including post traumatic stress disorder, insomnia, and paranoia).[3]

1 *Coalition to Abolish Slavery & Trafficking, www.castla.org/news/resources.htm.*
2 *Human Rights Center, U.C. Berkeley. Freedom Denied Forced Labor in California. February 2005.*
3 *Personal Communication. April 28, 2006. Namju Cho, Coalition to Abolition Slavery and Trafficking.*

REPORTED CASES OF HUMAN TRAFFICKING IN CALIFORNIA, INCLUDES MEN, WOMEN, AND CHILDREN, 2005
Source (II.20): Human Rights Center, U.C. Berkeley



NOTE: Each bar represents a percentage of the total populations of human trafficking cases.

HEALTH SERVICES USE

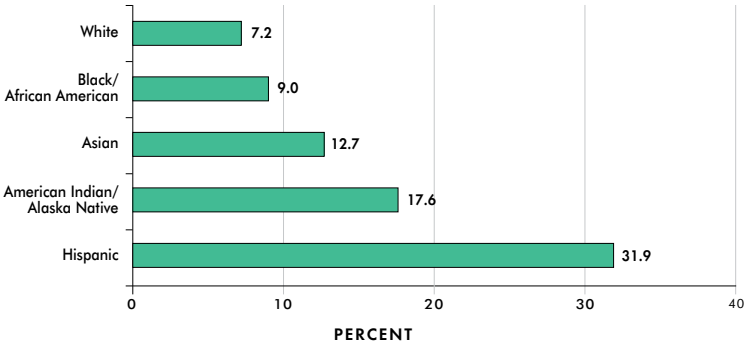
INTRODUCTION

Availability of quality health services and access to them directly affect the health and well-being of women. For women with poor health status and living in poverty, access to a range of health services and insurance can be critical in preventing disease and improving quality of life. The following section presents data on women's health services use, including indicators concerning insurance, usual source of care, and the use of hospital and mental health services.

HEALTH INSURANCE COVERAGE

People who are uninsured are less likely than those with health insurance to seek preventive care services, which can result in poor health outcomes and increased health care costs. The percentage of females who were uninsured in 2003 varied considerably between racial/ethnic groups. Non-Whites were considerably more likely than Whites to lack health coverage: 7.2 percent of White females were

UNINSURED CALIFORNIA FEMALES, BY RACE/ETHNICITY, 2003
Source (II.3): California Health Interview Survey



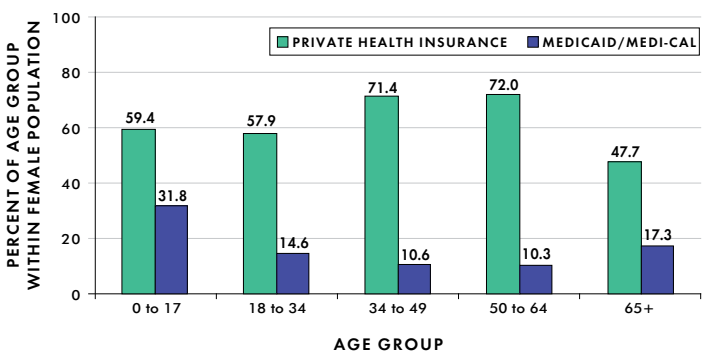
uninsured, compared with 31.9 percent of Hispanics, 17.6 percent of American Indian/Alaska Natives, 12.7 percent of Asians, and 9.0 percent of Black/African Americans.

The type of health insurance coverage also varied greatly by age in 2005. Females aged 35 to 49 or 50 to 64 years were most likely to have private health insurance (71.4 percent and 72.0 percent, respectively). Females aged 18 to 34 years or those above age 65 were least likely to have private health insurance (57.9 percent and 47.7 percent, respectively).

Nearly 32 percent of females 17 years and younger were covered by Medi-Cal. More than 90 percent of women over age 65 had Medicare coverage.

HEALTH INSURANCE COVERAGE OF FEMALES, BY TYPE OF COVERAGE AND AGE GROUP, CALIFORNIA 2005

Source (III.1): California Department of Finance, Current Population Survey



USUAL SOURCE OF CARE BY AGE GROUP AND RACE/ETHNICITY

Females of all ages who have a usual source of care (a place they usually go when they are sick or need health advice) are more likely to receive preventive care, to have access to care, to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[1-3]

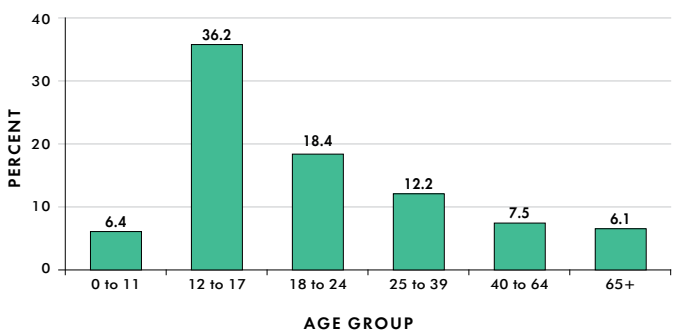
In 2003, the proportion of California females who reported lacking a usual source of care varied by age and racial/ethnic group. The highest proportion of females reporting that they lacked a usual source of care was the 12 to 17 year age group (36.2 percent). Children younger than 12 (6.4 percent) and adults 65 and older (6.1 percent) were the least likely to lack a usual source of care.

The proportion of females lacking a usual source of care also varied among racial and ethnic groups. More than 10 percent of Hispanics (13.6 percent), Native Americans (11.4 percent), and "others" (11.1 percent) reported lacking a usual source of care. Lower proportions of Asians (9.3 percent), Black/African Americans (8.3 percent), and Whites (6.8 percent) reported the same. Hispanic females were twice as likely to lack a usual source of care as Whites.

1 Ettner, S.L. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference. Medical Care 1999; 37(6): 647-655.
2 Sox CM, Swartz K, Burstin, HR, Brennan, TA. Insurance or a regular physician: which is the most powerful predictor of health care? American Journal of Public Health. 1998; 88(3): 364-370.
3 Weiss KH, Blustien, J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. American Journal of Public Health. 1996; 86(12): 1742-1747.

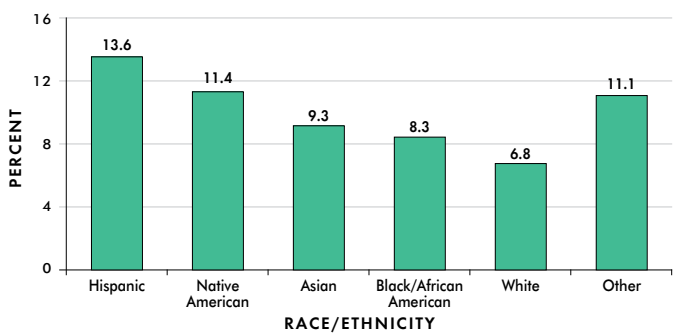
FEMALES WHO REPORTED LACKING A USUAL SOURCE OF CARE, BY AGE GROUP, 2003

Source (II.3): California Health Interview Survey



FEMALES WHO REPORTED LACKING A USUAL SOURCE OF CARE, BY RACE/ETHNICITY, 2003

Source (II.3): California Health Interview Survey



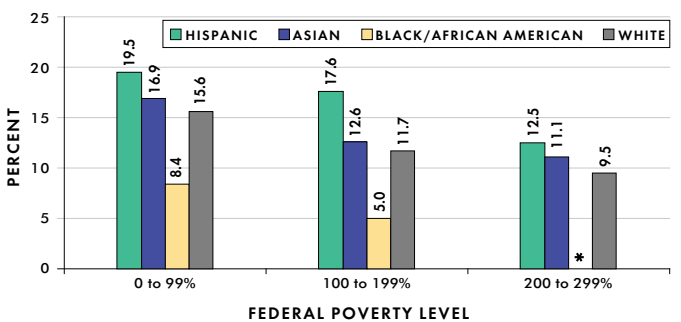
USUAL SOURCE OF CARE BY RACE/ETHNICITY AND INCOME LEVEL

Access to health services directly affects the health and well-being of women. Women who have a usual source of care (a place they usually go when they are sick or need health advice) are more likely to receive preventive care,[1] to have access to care (as indicated by not delaying seeking care when needed),[2] to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3]

Whether women have a usual source of care varies among race/ethnicity group and income level. Poverty was associated with women lacking a usual source of care. Poverty status or federal poverty level (FPL) is set by the U.S. Census Bureau and varies depending on a person's family income, size, and composition.[4] Women with the lowest income levels were less likely to have identified a usual source of care than those with higher income levels. For women with income levels under 300 percent of the FPL, higher proportions of Hispanics reported not having a usual source of care than women of other race/ethnicities, followed by Asians and Whites. Black/African American women had the lowest levels of lacking a usual source of care at both 0 to 99 percent of the FPL and 100 to 199 percent of the FPL.

1 *Ettner, S.L. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference. Medical Care 1999; 37(6): 647-655.*
2 *Sox CM, Swartz K, Burstin, HR, Brennan, TA. Insurance or a regular physician: which is the most powerful predictor of health care? American Journal of Public Health. 1998; 88(3): 364-370.*
3 *Weiss KH, Blustien, J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. American Journal of Public Health. 1996; 86(12): 1742-1747.*
4 *U.S. Census, Poverty Status. 2000.*

CALIFORNIA WOMEN WHO DO NOT HAVE A USUAL SOURCE OF CARE, BY RACE/ETHNICITY AND FEDERAL POVERTY LEVEL (FPL), 2003
Source (II.3): California Health Interview Survey



*Data from 200-299% FPL lacked significance.

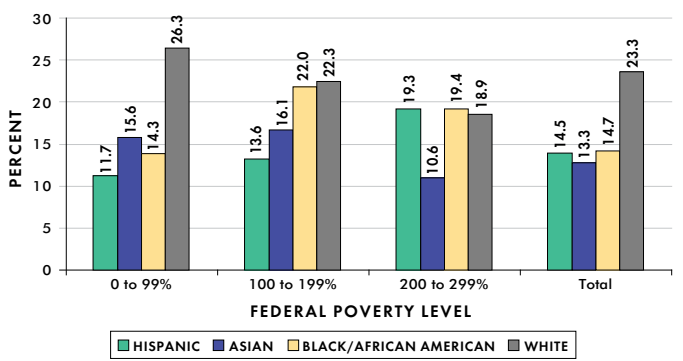
ACCESS TO CARE

Access to health services directly affects the health and well-being of women. Access to care is indicated by not delaying or seeking care when needed.[1] Women who have a usual source of care (a place they usually go when they are sick or need health advice) are more likely to receive preventive care,[2] to have access to care, to receive continuous care, and to have lower rates of hospitalization and lower health care costs.[3]

Access to care varies among income levels and race/ethnicity. Poverty status, or federal poverty level (FPL), is set by the U.S. Census Bureau and varies depending on a person's family income, size, and composition.[4] Over 25 percent of White women living within 0 to 99 percent of the FPL delayed care or did not get care. Black/African Americans and Whites living within 100 to 199 percent of FPL also had high rates of delaying or not getting care (22.0 percent and 22.3 percent, respectively).

1 Sox CM, Swartz K, Burstin, HR, Brennan, TA. Insurance or a regular physician: which is the most powerful predictor of health care? American Journal of Public Health. 1998; 88(3): 364-370.
2 Ettner, S.L. The relationship between continuity of care and the health behaviors of patients: does a usual physician make a difference. Medical Care 1999; 37(6): 647-655.
3 Weiss KH, Blustien, J. Faithful patients: the effect of long-term physician-patient relationships on the cost and use of health care by older Americans. American Journal of Public Health. 1996; 86(12): 1742-1747.
4 U.S. Census Bureau, Poverty Status, 2000.

CALIFORNIA WOMEN WHO DELAYED CARE OR DIDN'T SEEK CARE, BY RACE/ETHNICITY AND FEDERAL POVERTY LEVEL, 2003
Source (II.3): California Health Interview Survey



MENTAL HEALTH CARE USE

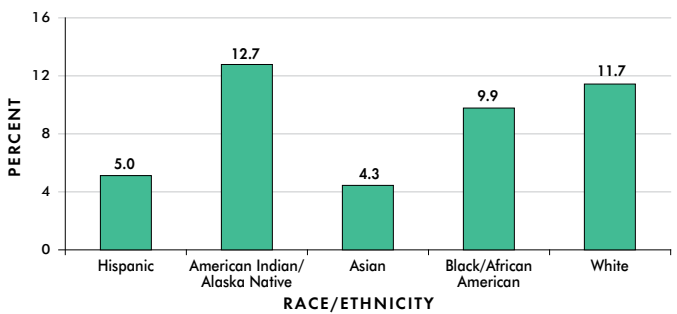
As highlighted by the Surgeon General's report on mental health, relatively few adults who experience mental health disorders obtain care.[1] The proportion of women seeing a health professional for emotional/mental problems varied by race/ethnicity. In 2001, Black/African Americans, Hispanics and Asians were far less likely to use mental health services (9.9 percent, 5.0 percent, and 4.3 percent, respectively) than were Whites and American Indians/ Alaska Natives (11.7 percent and 12.7 percent).

The use of a prescription medication for an emotional or personal problem varied significantly by age. Of the women who needed help for an emotional or mental health problem, higher proportions of women 40 years or older were taking a prescription medicine for that problem than were women in other age groups. Conversely, the age group with the lowest rate of taking prescription medicine for emotional or mental health problems was 18 to 24 years.

1 *U.S. Department of Health and Human Services. Mental Health: A report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.*

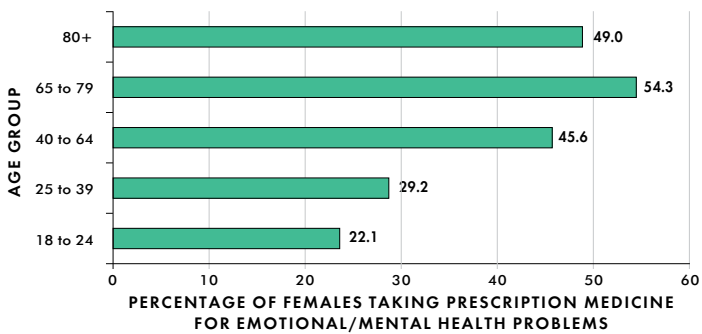
CALIFORNIA FEMALES WHO SAW HEALTH PROFESSIONALS FOR EMOTIONAL/MENTAL PROBLEMS, BY RACE/ETHNICITY 2001

Source (II.9): California Health Interview Survey



CALIFORNIA FEMALES TAKING PRESCIPTION MEDICINE FOR EMOTIONAL/MENTAL HEALTH PROBLEMS, BY AGE GROUP, 2001*

Source (II.9): California Health Interview Survey



*Percentages do not reflect the general population. Respondents were selected from a group of women reporting "Needing Help for an Emotional/Health Problem".

HOSPITALIZATIONS

Women composed 59 percent of the approximately 4 million hospital discharges in California in 2004.[1] About 30 percent of hospital discharges in California were related to pregnancy, and obstetrical procedures accounted for 21.5 percent of hospital inpatient procedures in 2000.

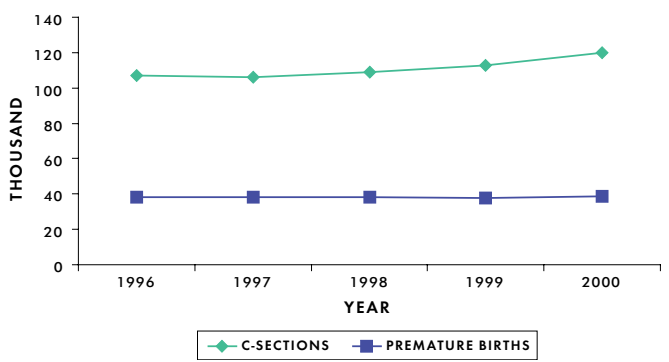
The number of premature births did not increase in California from 1996 through 2000, but the number of Cesarean sections (C-sections) did.[2] C-sections constituted 21.1 percent of all deliveries in 1996 and 23.7 percent in 2000.[3]

Black/African American women had the highest rates of "ambulatory care sensitive" conditions than other racial/ethnic groups. This is defined as conditions in which hospital admissions can sometimes be prevented with proper primary care, such as congestive heart failure, chronic obstructive pulmonary disease, diabetes and hypertension.

1 *The Office of Statewide Health Planning and Development (OSHPD) http://www.oshpd.state.ca.us/index.htm.*
2 *California Perspectives in Health care. http://www.oshpd.state.ca.us/HQAD/Perspectives/index.htm.*
3 *The Office of Statewide Health Planning and Development (OSHPD) http://www.oshpd.state.ca.us/HQAD/PatientLevel/index2.htm#PDP.*

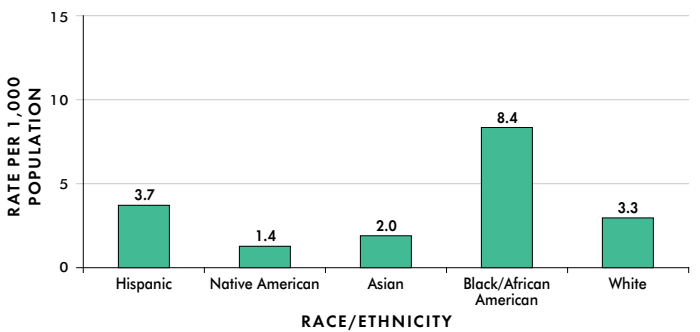
PREMATURE BIRTHS AND CESAREAN SECTION (C-SECTIONS) DELIVERIES, 1996-2000, IN THOUSANDS

Source (III.2): State of California, Office of Statewide Health Planning and Development



RATES OF "AMBULATORY CARE SENSITIVE" CONDITIONS*, BY RACE/ETHNICITY, CALIFORNIA 1999

Source (III.2): State of California, Office of Statewide Health Planning and Development



* Such as asthma, congestive heart failure, chronic obstructive pulmonary disease, diabetes, hypertension




SOURCES

SOURCES

POPULATION CHARACTERISTICS

I.1: U.S. Census Bureau, American Community Survey, 2004.

I.2 : U.S. Census Bureau, 2000.

HEALTH STATUS

II.1: California Department of Health Services. California Women's Health Survey (CWHS). 2003-2004 Data Points. http://www.dhs.ca.gov/director/owh/owh_main/cwhs/wmns_hlth_survey/survey.htm.

II.2: California Department of Health Services, Office of AIDS, HIV/AIDS Case Registry Section, data as of January 31, 2006.

II.3: California Health Interview Survey (CHIS), 2003.

II.4: California Department of Health Services, California Cancer Registry, 2000.

II.5: California Office of Statewide Health Planning and Development, Patient Discharge Data, 2003.

II.6: California Department of Health Services, Death Records, 2003.

II.7: Women's Health and Mortality Chartbook, Centers for Disease Control and Prevention/Department of Health and Human Services, California 2000.

II.8: California Health Interview Survey (CHIS), 2001.

II.9: California Department of Health Services, Center for Health Statistics. Suicide Deaths California, 2000-2003.

II.10: California Department of Health Services, Sexually Transmitted Disease Control Branch. 09/2005 Provisional Data.

II.11: California Department of Health Services. Epidemiology and Evaluation Section, Maternal, Child and Adolescent Health/Office of Family Planning Branch. Birth Statistical Master File, 1995-2004.

II.12: California Department of Health Services, Birth Statistical Master File, years 1970-2004. Teen population: Years 1970, 1980, State of California, Department of Finance, Provisional Estimated Population, December 15, 1971. Years 1990-2004, California Department of Finance, Race/Ethnic Population with Age Group and Gender Detail, 1990-1999 and 2000-2005. Sacramento, CA, May 2004. U.S. data source: years 1970-2002; National Vital Statistics Report, Vol. 52, No. 10, December 17, 2003. U.S. data source for 2003 and 2004; National Vital Statistics Report, Vol. 54, No. 8, December 29, 2005.

II.13: California Department of Health Services, Birth Statistical Master File, years 2002-2004. Teen population: State of California, Department of Finance: Race/Ethnic Population with Age Group and Gender Detail, 2000-2005. Sacramento, CA, May 2004.

II.14: California Department of Health Services, Epidemiology and Evaluation Section, Maternal, Child and Adolescent Health/Office of Family Planning Branch, Genetic Disease Branch, Newborn Screening Database, 2004.

II.15: Maternal and Infant Health Assessment (MIHA), 2004.

II.16: California Department of Health Services, California Birth and Death Statistical Master Files, 1991-2004. Maternal mortality (deaths ² 42 days postpartum) calculated 1991-1998 using ICD-9 classification. Pregnancy-related mortality (deaths ² 365 days postpartum) calculated beginning 1999 using ICD-10 classification. HP2010 Objective is for maternal mortality. Produced by California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, March 2006.

II.17: California Department of Health Services, California Birth and Death Statistical Master Files, 1990-2004. Maternal mortality (deaths ²42 days postpartum) calculated 1990-1998 using ICD-9 classification. Pregnancy-related mortality (deaths ² 365 days postpartum) calculated beginning 1999 using ICD-10 classification. Maternal single race code used 1990-1999; multirace code used beginning 2000. Produced by California Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, March 2006.

II.18: California Department of Health Services, Center for Health Statistics, 2003.

II.19: Human Rights Center, U.C. Berkeley. Freedom Denied Forced Labor in California. February 2005.

HEALTH SERVICES USE

III.1: California Department of Finance, Demographic Research Unit. Current Population Survey Report, March 2005.

III.2: State of California. Office of Statewide Health Planning and Development. Patient Discharge Data, 2000.

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www.dhs.ca.gov/director/owh